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ABSTRACT

England's preregistration undergraduate degree in nursing and midwifery programs were subjected to a comprehensive evaluation that included the following data collection activities: in-depth field studies of 26 of 32 three- and four-year undergraduate nursing and midwifery programs; individual interviews with 129 lecturers, 54 students, 52 clinicians, and 47 program graduates; group interviews with 8 lecturers, 28 students, and 5 clinicians; and telephone interviews with 7 national policymakers and 7 course leaders. The study focused on the following: development/reform of undergraduate nursing/midwifery education; curriculum development/implementation; clinical learning resources/environments; student learning objectives and strategies; informal/formal monitoring of degree programs; student finances and part-time work; student roles in programs; and program outcomes. The study established that preregistration undergraduate programs in nursing and midwifery have maintained relatively low attrition rates and produced qualified graduates who have overwhelmingly gone into clinical practice. Principles/criteria determining the quality of the following aspects of undergraduate degree programs were identified: structuring the education process; avoiding unacceptable compromise; planning for/creating coherence; achieving quality, range, and relevance of learning experience; emphasizing educational dialogue; supporting critical reflection; and providing support for teaching staff and liaisons with clinical staff. (Thirteen tables/figures and 114 references are included.) (MN)

ED 398 403

THE EVALUATION OF PRE-REGISTRATION UNDERGRADUATE DEGREES IN NURSING AND MIDWIFERY PROGRAMMES

Terry Phillips
John Schostak
Helen Bedford
Jen Leamon

University of East Anglia

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EVALUATION OF PRE-REGISTRATION UNDERGRADUATE DEGREES IN NURSING AND MIDWIFERY

PREFACE

The Board is pleased to publish this evaluation of three and four year undergraduate programmes in nursing and midwifery. The research sought the views of participants and followed graduates into practice to identify the principles which led to the creation of successful degree programmes. The evaluation offers material which will enable institutions and policy makers a means of exploring their own structures in the light of the descriptions, analyses and models offered in the report.

Through a variety of means the Board ensures that education for practice continues to be relevant both professionally and academically. Research based evidence provides a further important dimension for the development of policy. The findings from all the research commissioned by the Board will be considered with a view to confirming or developing the Boards educational policies.

M. Theobald

Maureen Theobald
Chairman of the Board

Jeff Thompson

Professor Jeff Thompson
Chairman of the Research and Development Group

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REFERENCES

TYDE Team Core Members

Helen Bedford	Senior Research Associate (Nursing), CARE (Centre for University of East Anglia
Jen Leamon	Research Associate (Midwifery), CARE (Centre for Applied Research in Education), University of East Anglia/Senior Lecturer – Midwifery, School of Nursing and Midwifery, Faculty of Health and Applied Science, Suffolk College
Terry Phillips	Project Director/Lecturer of Education, School of Education and Professional Development, University of East Anglia
John Schostak	Project Director/Professor of Education, School of Education and Professional Development, University of East Anglia

TYDE Senior Team Members

Julia Allison	(November 1992–April 1994) Formerly Director of Midwifery Education, Norfolk and Norwich College of Nursing and Midwifery
Gill Aspinall	Senior Occupational Therapist Manager, St Andrews Hospital, Norwich
John Elliott	Dean (Professor of Education) of the School of Education and Professional Development, University of East Anglia
Kate Jackson	Director, Changing Childbirth Implementation Team
Barry MacDonald	Director of CARE (Centre for Applied Research in Education)/ Professor of Education, University of East Anglia
Nigel Norris	Senior Lecturer in Education, CARE (Centre for Applied Research in Education), University of East Anglia
Jill Robinson	Head of Nursing and Health Care Research Unit, Faculty of Health and Applied Sciences, Suffolk College

Secretarial support

Jill Corcoran, Miriam McGregor, Laura Tickner and Barbara Walker.

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Under any circumstances such contributions could be regarded as generous, however as this final report illustrates, the contexts of change, uncertainty and pressure in which individuals work and learn serves to further illuminate their commitment.

We wish them continued success.

Note

The identities of all persons, degree programmes and institutions referred to in data extracts contained within this final report have been changed to ensure anonymity.

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CHAPTER ONE

The research background and perspective

Introduction

The scope of the TYDE project is ambitious, being national in focus and qualitative in method. Its aspiration is to grasp the complexity of the realities faced by educationalists, students, graduates and clinical practitioners. The intention of this report is to ensure that the complexity of the reality studied by the project is not reduced simply for the ease of making policy decisions or developing management mechanisms and strategies. The aim is to provide data to facilitate a creative response to the issues in nurse and midwife undergraduate education.

1.1 The costs and achievements of degree level education

This report documents an evaluation of pre-registration nursing and midwifery undergraduate degree programmes at a time of unprecedented social, economic, and technological change.

Nursing and midwifery educators have to prepare students to be financially, legally, and managerially accountable as well as clinically competent. They also have to enable them to work out new ways of interacting with clients, collaborating with other professionals, and achieving the competencies necessary for transformed professional roles. In responding to such a demanding task they are bound to have both successes and difficulties.

The report details some of the costs of innovation in nursing and midwifery education. Chief among these are individual well-being and institutional cohesion. In the early stages, the personal costs of nursing and midwifery education at degree level are high. But the report also shows that much can be achieved once a course has progressed beyond the initial period of disruption caused by innovation. At the point where departments develop more effective structures for planning, communication, and management, together with a coherent notion of their 'discipline', some of the pressures on lecturers and students are reduced.

In providing evidence of the difficulties experienced by nursing and midwifery teachers and students in relation to undergraduate programmes, the report could inadvertently create the impression that there have been few successes. We wish to emphasise, therefore, that developments are considerable.

Despite being caught up in multi-layered innovation over the past decade and – like other professional educators – being sent spinning from time to time by the many and complex, inter-related currents which criss-cross at different levels in their particular professional 'ocean', nursing and midwifery educators, students, graduates and clinicians have successfully charted a course through unsettled and unpredictable waters. These achievements are due in no small measure to their creativity, and to the quality of their relationships with other staff in HE and clinical settings. Together these have resulted in curricula which have developed new knowledge through collaborative enterprise. It is our view that this endeavour has placed nursing and midwifery education at the forefront of educational thinking and practice for the professions.

1.2 Purpose of the report

The report offers evidence that the quality of nursing and midwifery undergraduate education, and the extent of the stress experienced in achieving it, both depend upon the availability of resources and structures to enable processes of co-ordination, negotiation, and clarification. It presents a broad picture of the experiences of individuals involved in pre-registration degree programmes in nursing and midwifery. It focuses on identifying the principles which might inform the establishment of key criteria for formative evaluation of the quality of a degree, and through them seeks to facilitate debate and judgement.

The evidence draws attention to a cluster of issues faced by all degree providers and reveals how, in the course of actually 'delivering' a degree, providers are exploring such questions as:

- what does it mean in personal, social and cultural terms to provide or receive a *degree level* education?

- what are the features which distinguish a *professional* degree from any other?

- what are the *organisational* and *management* issues of degree level education for professionals ?

The report records attempts to unpack each of these questions and the complex issues which they raise within the context of the social, political and policy changes that have characterised the 1980's and 1990's. In doing so it sets the questions into broader contexts of debate. The focus is on a range of implicit and/or explicit assumptions about a) student and professional learning, b) the rationale for reform , c) the forms of organisation required to deliver education for entry into the professions, d) the development of learning environments, e) the development of curricula, f) the professional development of staff, g) the ways in which staff articulate vision(s) for the development of nursing and midwifery, and h) change and innovation.
The report attempts to portray key experiences and draw from these the kinds of discourses, implicit structural material conditions and the theories underlying professional action.

It is anticipated that the experiences and learning portrayed in the report will be of value to those planning new undergraduate programmes, and those re-validating existing programmes.

1.3 Central arguments of the report

1.3.1 Methodological arguments.

The methodological arguments in this report refer to the research perspective and the associated processes through which data was collected and interpreted. In brief, the approach is qualitative and employs case study methodologies to produce grounded theory for the purpose of evaluation. The research has drawn upon the developing debates concerning qualitative research (Glaser and Strauss 1967; Simons 1980; Ragin and Becker 1992) and evaluation (Murphy and Torrance 1987; Norris 1990; House 1993). It has also developed its own approach, influenced by the emergent debates concerning post-modern society, the relation between the local and the global, and the processes and techniques of research appropriate to contemporary material and social conditions. Insight has been drawn from the critical realism promoted philosophically by Bhaskar (1993) and sociologically by Sayer (1993).

The evaluation methodology is to present issues, interests and concerns as an evidence base which may inform policy making. It goes beyond portrayal to offer an argument which facilitates discussion about the relationships which organise discourses, practices, resource allocations, management, and institutional order and change.

1.3.2. Substantive arguments.

The substantive issues are grounded in the data collected, through the guidelines offered by the methodological approach.

The first argument concerns the issue of comparison. This evaluation was commissioned for a period of three years (November 1992 – October 1995) with the purpose of comparing the effectiveness of three and four year undergraduate programmes in nursing and midwifery, looking in particular at the pressures made by undergraduate programmes on staff, students and standards. The picture revealed is a highly complex one and confirms that simplistic 'three years versus four years' comparisons are inappropriate and misleading.

For a comparison to be both fair and useful in informing judgement there would need to be sufficient in common between the institutions being compared to be able to show that differences in key outcomes are due to a particular set of variables and not some other set of variables. This is not possible, however. It is easy enough to place institutions into crude categories such as *'new university', 'old university'*, or *'newly merged institution'* and to place these into a matrix with *'three year degree', 'four year degree'*. It is even possible to begin to make these categorisations more sophisticated by adding in further dimensions such as: *'actual teaching weeks per degree type', 'entry requirements', 'age profiles' 'qualifications profiles,'* and *'resourcing levels'*. It soon becomes apparent, however, that categorisations of this sort are arbitrary and can be extended indefinitely. Instead of looking for categories for comparison, it is argued, it is more appropriate to look at each programme in its unique institutional context, and explore the relationships and structures which enable programme delivery in context.

A corollary of this argument is that uniqueness at the local level renders institutional comparison and generalisation highly problematic if not impossible. In this argument, data reveals the ways in which institutions are organised to respond to local contexts. It suggests that evaluation is the study of the extent to which a given pattern of organisation is appropriate to meet local and global demands.

In the report it is further argued that the structures that institutions have to deal with are neither stable nor simple. The particular ways in which each institution 'reads' or interprets these multi-layered contextual structures defines the institution itself. This argument perceives such difference as desirable during periods of rapid change, allowing appropriate responses to variations and unique circumstances in local contexts.

Finally, the report makes a case that, while local variation is a necessity to meet changing and complex demands, it can be regarded as local 'experimentation' that can be shared through dialogue. Such experimentation can form the basis for mutual learning and the development of shared understandings, principles and criteria. From the processes of sharing and learning, institutions may adopt the successful approaches of others and interpret them for their own context.

These general arguments underlie the detailed portrayals, analyses and arguments in the report.

1.4 Structure of the report

The report is divided into three parts:

- **Historical background and transition (Chapters 2,3)**
This initial part provides a context to the development and current operation of undergraduate programmes. It reveals the complexity of contemporary changes impacting upon the working lives of staff and students.

- **The voice of experience (Chapters 4-12)**
From the many staff, students and graduates interviewed, an overview of every aspect of undergraduate programmes is developed. It provides a data base for discussing issues ranging from course planning to course delivery, taking in such key themes as course philosophy, course monitoring and quality assurance, the processes of both staff and student professional development, resourcing and staff and student pressure.

- **Professional education in a degree programme (Chapters 13, 14)**
In this final section the question of quality in professional education is addressed by developing a model of the nature and processes underlying good practice. It is not intended to be definitive. Guideline criteria are offered for discussion in the hope that

they may contribute to decision making regarding the development, validation and delivery of degree level professional programmes.

1.5 Organisation of the research

All three and four year undergraduate nursing and midwifery programmes operating in England at the start of academic years 1992 and 1993[1] (see Table 2a in Chapter 2) were invited to participate in the TYDE project. Responses were positive, and 26 institutions agreed to participate[2]. Six of the 32[3] nursing and midwifery programmes declined to participate (two of the three year, and four of the four year, nursing degrees), citing reasons of institutional pressures or heavy commitments to research.

The evaluation focused on the personal and social experiences of teaching and learning, as well as on formal procedures and structures. Data was collected data via interviews, document analysis and (during Phase 1) observation.

Data collection was in two phases as follows:

- **Phase 1 (Nov. 1992 – Oct. 1993)**

This involved a dual fieldwork strategy to ensure breadth and depth of initial data collection:

Initial in-depth fieldwork. All three year[4] degree courses participating in the project (five nursing and three midwifery), and a similar number of four year degree courses were included in this fieldwork category. Intensive periods of data collection were undertaken. This initial fieldwork was exploratory, gathering and analysing data which included historical details, curricula and the experiences and perspectives of staff (with a variety of teaching, clinical, research and management roles) and students. Individual and group interviews and observations of the courses in action were undertaken. Course-related documentation was collected during this first phase (and throughout the lifetime project to update documentation whenever possible) for analysis. Documentation included curriculum documents, student handbooks, assessment strategies, and annual/periodic review/evaluation reports

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[1] One three year degree which commenced in 1993 was unfortunately not included in the evaluation data base due to the project team receiving incorrect information regarding its operation. This highlights the difficulties experienced in creating and maintaining an up to data base, as information in the UCAS guides and HE prospectuses is not always up to date. The research team endeavoured to check all listings by telephoning individual institutions.

[2] As the evaluation progressed, one three year nursing degree and one four year midwifery degree were only able to offer limited access due to internal research pressures/institutional amalgamation, and external research pressures respectively.

[3] From Table 2a in Chapter 2, it is apparent that a total of 33 degrees were operating (three and four year nursing and midwifery programmes), however only 32 programmes were invited to participate, as one course was inadvertently excluded in the database (see footnote 1).

[4] Categorising some degree programmes by length was not a clear cut exercise; one programme of three years followed by an 11 week practice period was included in the three year category; one programme lasting three year and one semester programme was included in the four year category.

Course profiles. All remaining four year courses were approached to participate in the research via data collection for a profile of their course. Areas covered in the profile ranged from the history and development of the course and the department, through to course issues such as curriculum, assessment and organisation structures, and also included student and staff topics such as support and communication. Data was collected via documentation, a one day visit to interview the course leader or other appropriate members of staff, and follow up telephone contact where necessary to complete the profile.

In addition, national policy issues were explored via interviews with key figures. Analysis and regular TYDE research team discussion of data collected during Phase 1 of the project resulted in the writing of working papers and progressive focusing of issues and themes for Phase 2 fieldwork.

- **Phase 2 (Oct. 1993 – Oct. 1995)**

During this final, two year phase, fieldwork was arranged to follow up issues in institutions which were designated 'core programme', 'theme programme', or 'response' institutions. The focus in each case differed as follows:

Core Programme Institutions. These were the main focus of fieldwork during Phase 2. 8 undergraduate programmes (i.e. 4 three year degrees - 2 nursing and 2 midwifery - and 4 four year degrees - again 2 nursing and 2 midwifery) were designated in the core grouping. Fieldwork with these courses built on existing data, creating more detailed case studies and developing understandings of what constitutes a professional degree in each unique context. Key themes pursued in Phase 2 related to the 'outcomes' of the degree programmes in its widest sense. This involved the follow-up of new and more experienced graduates, and exploration of the structures and mechanisms for course evaluation and monitoring. Interviews were also held with employers of graduate practitioners (at varying levels of experience), and lecturers reflecting on the undergraduate programmes.

Theme Programme Institutions. Within this group, undergraduate programmes were included on the basis of themes identified during Phase 1 requiring further exploration. Fieldwork involved short visits and telephone contact to institutions to explore such issues as support for students and staff, evaluation and monitoring of courses, the notion of 'standards' and shared learning.

Response Institutions. This grouping of courses provided a vital national context for exploring, checking, verifying or refuting issues emerging from core and theme courses during Phase 2. Telephone interviews and requests for responses to issues raised in TYDE publications were the main focus of this contact.

The project Interim Report was also written during Phase 2, providing a useful basis for discussion with participating institutions.

In total, during Phases 1 & 2, the following number of interviews were conducted:

16

	interviews with individuals	interviews with groups[5]
Lecturers	129[6] (n=99 m=30)	8 (n=6 m=2)
Students	54 (n=29 m=25)	28 (n=21 m=7)
Clinicians (all Levels)	52 (n=30 m=22)	5(m=5)
Graduates	47 (n=39 m=8)	–

In addition, 7 interviews were conducted with national policy makers, and 7 telephone interviews were held with course leaders, to discuss the project interim report and update on developments to the undergraduate programmes.

1.6 The key principles identified

The principles which emerge from the research recognise the embedded nature of teaching and learning. They emphasise the need to ensure:

- organisational sensitivity to internal and external constraints;
- communication to all levels in the system and at all key stages in the process of education;
- the structuring of 'voices' to facilitate dialogue;
- a clear link between dialogue, feedback, and resultant action, development, and learning.

The report reveals a need for imagination and careful structuring of courses to enable the implementation of these principles. These qualities are facilitated by the provision of appropriate resources for effective implementation.

1.7 Summary

This report offers a comprehensive account of successes and problems in the development and delivery of undergraduate nursing and midwifery degrees. It presents evidence of commitment and hard work in circumstances that are often stressful. It indicates the principles which seem to facilitate the promotion of quality in degree programmes and by implication provides an insight into the sorts of criteria that might be applied to evaluate other professional degrees It shows that in many respects nursing and midwifery educators are leading the way in curriculum innovation for degree-level professional education.

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[5] Group size varied from two to six interviewees.

[6] This includes 12 lecturer practitioners.

PART ONE

Historical background and transition

CHAPTER TWO

A history of pre-registration undergraduate programmes in nursing and midwifery

Introduction

This chapter provides an overview of developments in pre-registration undergraduate education in nursing and midwifery up to the present time. It charts the histories of degree programmes alongside the mainstream training routes into both professions. It identifies the distinct developmental paths of degrees in nursing and midwifery, and outlines changes within the lifetime of the TYDE project.

2.1 The development of undergraduate nursing education

Throughout this century apprenticeship models of training have dominated nursing education. Despite frequent calls for reform (Ministry of Health 1947; Royal College of Nursing 1964; Royal College of Nursing, Commission on Nursing Education 1985), nursing remained as a practice-based occupation with education subordinate to the needs of service until the late 1980's and early 1990's, when widespread reform occurred with the introduction of the Project 2000 proposals (UKCC 1986).

However since the 1960's a small number of pre-registration undergraduate nursing courses have been established. The first UK programme was validated at Edinburgh University in 1960 (Altschul 1987). Shortly after this, nursing degrees were established in universities, and later in the polytechnic sector, in England. There was considerable variation in the nature of the degrees offered in combination with a nursing qualification, for example nursing studies, nursing sciences, social sciences or economics (Emblin & Hill 1976a, 1976b & 1976c). Whilst most courses combined a degree with a State Registered Nurse or Registered General Nurse qualification, a small number offered an Registered Mental Nurse (RMN) option, and others offered opportunities to complete post registration courses in community nursing within a total degree course package. The length of the degrees varied too, between four to five years, often requiring study in extended academic terms (Emblin & Hill 1976a, 1976b & 1976c).

The pre-registration degrees were relatively small in number in comparison to mainstream certificated nursing programmes. The degrees combined a strong academic base with clinical practice, and since their inception they have been perceived as threatening to the status quo of nursing, medicine and universities (MacFarlane 1987). Their markedly different approach to professional education led to reports of undergraduate students feeling 'different' from other nursing students, occupying more ambiguous roles in clinical settings and being less socialised into workplace cultures (Luker 1984; Smithers & Bircumshaw 1988; Ashworth and Morrison 1989). Widespread misconceptions surrounded the nature of graduates in practice, namely that they failed to enter nursing practice, spent little time in clinical posts and were rapidly promoted into managerial positions (Sinclair 1987). Follow up studies of graduates refuted these fallacies and indicated that very high proportions of graduates embark on clinical careers and stay working in practice (Marsh 1976; Reid et al 1987; Kemp 1990). The research highlighted the trend for graduates to move into areas of practice such as community care or midwifery which provide greater opportunity for autonomous practice. Professional development was found to feature strongly in graduate career paths, frequently focusing on clinical practice and research.

In 1988 an expansion of undergraduate nursing education was recommended by the University Grants Committee Panel on Studies Allied to Medicine and supported by the Department of Health and the Department of Education and Science (ENB 1993a). This expansion advocated increasing both the number of courses and the number of places available on existing courses. The UGC recommended that all courses be four years in length, and set a target of at least one course per Regional Health Authority (ENB 1993a).

Around this time, growth of the undergraduate programmes in the polytechnic sector also occurred, supported by the Polytechnics and Colleges Funding Council (PCFC). The PCFC proposed that course length be reduced to three years. In January 1989 a consultative Nurse Education Advisory Group was established with representation from the ENB, DoH, DES and senior nurse educationalists from the former polytechnic sector. The remit of this group was as follows:

> *To consider and co-ordinate preparations for a combined three year course of education and training leading to a degree in nursing and a professional qualification.*
> (PCFC 1989 p1)

In March 1989 the group concluded that combined three year courses leading to degrees in nursing at honours level and a professional qualification could be developed without a loss of quality. However the group drew attention to the need for institutions to, *"respond imaginatively to the challenges posed by the development,"* (PCFC 1989 p11) and identified a series of issues which institutions planning and delivering three year undergraduate programmes would be required to address:

- Entry requirements
- Course length
- Impact on students
- Impact on staff
- Structure
- Content
- Practice based learning
- Assessment
- Staff development
- Evaluation

With acknowledgement of the anticipated pressures, the ENB supported the move to develop a limited number of three year programmes (ENB 1994a).

The expansion of undergraduate programmes in the late 1980's coincided with the introduction of the United Kingdom Central Council's (UKCC) extensive review of nurse education, 'Project 2000: A New Preparation for Practice' (UKCC 1986). The report made 25 recommendations (UKCC 1986 p70), and after a period of debate, discussion and amendment to some initial proposals, Project 2000 was launched in late 1989 and early

1990 in the form of diploma level programmes in thirteen demonstration districts. Project 2000 principles have now been adopted throughout the UK. Whilst the majority of Project 2000 programmes are at diploma level, undergraduate programmes must now operate on Project 2000 principles. Key features of the Project 2000 programmes which relate to the undergraduate degree programmes are as follows:

- registration on newly created parts of the UKCC Register (Parts 12-15), which recognise the nurses ability to practice in institutional and community settings;
- a revised set of nursing competencies to be achieved (Rule 18a);
- initial common foundation programme followed by progression to nursing specialisation in a choice of branches/Parts of the UKCC Register:
  adult nursing (Part 12)
  mental health nursing (Part 13)
  learning disabilities nursing (Part 14)
  children's nursing (Part 15).

Adoption of Project 2000 principles has enabled the introduction of the first pre-registration routes into learning disabilities nursing and children's nursing at degree level, and a revival of the option to study mental health nursing at this level.

2.2 The development of undergraduate midwifery education

Pre-registration undergraduate programmes in midwifery are a more recent innovation, occurring during a decade of unprecedented change in midwifery education and practice.

Since the first Midwives Act of 1902, there have been two routes leading to registration as a midwife. The majority of student midwives entered training via post-registration programmes[1], having previously qualified as first level nurses. The alternative 'direct entry' route was taken by a small number of students without prior nursing registration. By 1983 only one three year 'direct entry' programme existed at Derby City Hospital, which recruited an annual intake of eight students (Radford & Thompson 1988a).

The provision of midwifery education via nursing or 'direct entry' routes has been the subject of much debate throughout this century, often in association with changing perceptions of the normality or otherwise of the childbirth process. A Ministry of Health committee chaired by Bolam (Ministry of Health 1929), stated that all future midwives should possess a nursing qualification; however recommendations from this report were never implemented.

The Report of the Working Party on Midwives, chaired by Stocks (Ministry of Health 1949) again reviewed educational provision. The Working Party noted fundamental differences between nursing and midwifery, and expressed the view that a nursing qualification was not an essential prerequisite to midwifery. However, they concluded that midwives should possess a nursing qualification prior to entry and the direct route should be discontinued, due to the relative scarcity of non nurse midwives and their inequitable opportunities for promotion.

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[1] Now termed 'pre-registration (shortened)' programmes.

Once again, recommendations resulting from a major review of midwifery education were never implemented. However, the suggestion of a common initial training with nurses followed by midwifery specialisation which appeared in The Report of the Working Party on Midwives (Ministry of Health 1949) prefigured recommendations from The Report on the Committee on Nursing, chaired by Asa Briggs (HMSO 1972). The Report on the Committee on Nursing noted that the majority of midwives possessed a nursing qualification, and went on to endorse the study of an 18 month common nursing core prior to a further 18 months specialisation in midwifery.

Although no action was taken as a result of The Report on the Committee on Nursing, there was the suggestion that midwifery become a branch option following a shared a common foundation course with nursing reappeared with the publication of the 'Project 2000: A New Preparation For Practice' (UKCC 1986 p50-51). This branch proposal was unanimously rejected by the midwifery profession, although some aspects of Project 2000 were seen as beneficial to midwifery education and practice. In its response to the Project 2000 proposals presented in, 'Comments by the Royal College of Midwives on UKCC Project 2000: A new Preparation For Practice' (Royal College of Midwives 1987), the Royal College of Midwives was pleased to note the following UKCC statement:

> *In coming to this decision, we have accepted that midwifery is a profession different from but complementary to nursing. The role of the midwife can be said to be substantially different from that of the nurse in that a midwife potentially has greater professional independence as the level of decision-making is of a different order. The midwife is expected to have diagnostic skills relating to both the mother and baby that are at one level similar to the obstetrician, and indeed that there is an overlap of skills between the two. Midwives also have a limited responsibility to prescribe certain scheduled drugs and the right of referral to and discharge from hospital within limitations. All these ,together with the need for manual dexterity and to develop the confidence required to function in this way, point to a potentially special and different preparation for midwifery.*
> (UKCC 1986, p50, 6.33)

Support for a national expansion of the direct route into the profession and the academic development of courses was expressed in the Royal College of Midwives publication 'The Future Preparation of the Midwife' (Royal College of Midwives 1986) and the Association of Radical Midwives document 'The Vision' (Association of Radical Midwives 1986). The authors of 'The Vision' suggested the direct route should be three years in length and that students should be supernumerary and funded by a grant for the first two years, followed by a salaried final year (Association of Radical Midwives 1986).

Rekindled interest in direct entry midwifery education which occurred during the late 1980's was supported by the ENB, the Royal College of Midwives and the then DHSS

(Radford and Thompson 1988a). As a consequence, the ENB commissioned a year long investigation with the following research aims:

1. *To describe the national situation regarding direct entry midwifery training.*
2. *To discover the factors inhibiting development of such programmes.*
3. *To advise on issues which should be considered by those contemplating this option.*
4. *To recommend ways in which the establishment of non nursing midwifery training could be facilitated.*

(Radford & Thompson 1988a, p180)

The project team concluded that there was widespread enthusiasm for the development of direct entry programmes, which had previously been inhibited by pragmatic, historical and developmental factors. They noted the need for positive action to accelerate the development of the pre-registration route and recommended a series of targets for action (Radford & Thompson 1988b, p62, 64-70).

Pump priming monies for 14 pre-registration midwifery courses were made available by the DoH in two phases during 1989/1990 and 1990/1991 (Kent, MacKeith & Maggs 1994). The cost effectiveness of pre-registration midwifery education was recognised in the Working Paper 10 document (Department of Health 1989).

Since this time the development of pre-registration midwifery programmes has flourished, from an almost standing start to 34% of the student population on courses leading to midwifery registration by 1993 (ENB 1994). The emphasis of this growth has been at diploma level, however a small but growing number of undergraduate programmes have been established from 1989 onwards (Page & Healey 1990). The first midwives following pre-registration routes at diploma level and graduate level qualified in 1993 and 1994 respectively.

Pre-registration midwifery courses, at higher academic levels of diploma and degree represents a double innovation for curriculum planners and those involved with facilitating students' learning. At the present time there is small but growing body of published findings from internal and national evaluations of the programmes from which midwifery education can draw (Kent, MacKeith & Maggs 1994). Prior to this, development of undergraduate midwifery curricula relied on inter- and intra-institutional contact and published literature relating to pre-registration nursing degrees (Alexander 1993).

Radical reviews of maternity services are having significant impact on midwifery practice. Recommendations contained within the Department of Health: Maternity Services: Second report to the Health Service Select Committee (House of Commons 1992) and Changing Childbirth: Report of the Expert Maternity Group (Department of Health 1993) presented a paradigm shift in the orientation and organisation of care. The central themes of these two reports are that pregnancy and childbirth are normal processes, and that care should place women and their families centre stage, facilitating choice, control and continuity. The midwife has re-emerged as the primary health professional to facilitate the process of normal childbirth which is having a profound impact on the organisation and provision of maternity care in this country.

Those involved in the development, implementation and evaluation of midwifery curricular must integrate this vision to educate midwifery practitioners who are prepared for autonomous practice.

2.3 Recent developments in undergraduate education

There has been continued growth in the provision of pre-registration honours degrees in nursing and midwifery in England throughout the lifetime of the TYDE project (see Table 2a).

		Degree Length		
	Entry Year	Three years	Four years	Total
Nursing	1992	7	15	22
	1993	8	18	26
	1995	8	18	26
Midwifery	1992	3	2	5
	1993	3	4	7
	1995	2	9	11

Table 2a: Numbers of three and four year pre-registration nursing and midwifery degree programmes in England for entry in the academic years 1992 to 1995.

All but one of the undergraduate courses designated 'three year' have developed within the 'new' university sector. Two of the three year programmes superseded well established four year programmes, and one further programme was established in a department which had experience of operating a since discontinued four year undergraduate programme.

Within institutions, the undergraduate programmes are located in a range of organisational structures which reflect the academic focus and strengths of each individual degree. Examples are as follows[2]:

- BSc (Hons) Nursing, Department of Nursing Studies, Faculty of Medicine, 'Old' University (4 year);

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[2] All programmes included in the evaluation are at honours level, with the exception of one unclassified three year degree in midwifery and one three year nursing degree with options to study to ordinary or honours degree level. One nursing degree (not included in the study - see footnote 1 in Chapter 1) is three years for students choosing to do an ordinary degree, with the option of one further semester part time study for honours.

- BA (Hons) Midwifery, School of Health Care Studies, 'New' University (4 year);
- BSc (Hons) Nursing Studies, Department of Nursing and Midwifery, Faculty of Science, 'Old' University (4 year);
- BSc (Hons) Midwifery/BSc (Hons) Nursing, School of Initial Professional and Vocational Health Studies, Faculty of Health, 'New' University (4 year);
- BSc (Hons) Nursing Sciences, Health Sciences Division, School of Life Sciences, 'New' University (3 year);
- BSc (Hons) Nursing Studies, Division of Nursing and Midwifery Education, School of Education and Health Studies, 'New' University (3 year).

Throughout the project both the undergraduate programmes and the educational and clinical spheres in which operate continue to experience significant change. Many of the HE institutions operating undergraduate programmes have formed partnerships or have merged/integrated, uniting with NHS colleges of nursing and midwifery or health. (see Chapter 3). Such mergers are often require rethinking of pre-registration education as degree and diploma level courses are offered by merged institutions. Design of new courses and periodic revalidation of existing ones also has to take into account changes occurring in individual HE institutions, such as modularisation of courses and semesterisation. Greater emphasis is also currently being placed on multi-disciplinary and inter-professional shared learning and research (Department of Health 1994) between health related and allied professions (see Chapter 4).

2.4 Summary

Since the introduction of pre-registration undergraduate programmes in nursing in the 1960's, there has been a steady growth in provision, and significant development of individual programmes. The number of degrees has grown steadily and there has been significant change with the introduction of three year programmes (PCFC 1989). Undergraduate programmes in midwifery have been created along with the introduction of pre-registration midwifery education. In addition, the Project 2000 proposals (UKCC 1986) have created pre-registration degrees in child, mental health and learning disabilities nursing

Pre-registration undergraduate courses are increasingly less academically isolated from the mainstream as nursing and midwifery education moves into HE. Whilst numbers of pre-registration entrants into nursing and midwifery via the undergraduate route remain small in comparison to those attaining diploma status, they continue to grow, particularly in midwifery. This growth has been occurring alongside increased opportunities for post-registration study at diploma and graduate level.

Developments take place within the context of particular histories. It is typically argued that change is constrained by a given historical context. The legacies of history include the two broad strands within higher education currently talked about in terms of the 'old' and the 'new' universities. The 'old' tended to favour four year and the 'new' three year degrees although not in every case. Similar remarks may be made about the tendency for 'old' universities to favour more traditional academic research oriented approaches, whereas the 'new' are more inclined towards the vocational/professional and 'teaching' rather than research. Again, this is not true in every case. At another level, institutions had to respond to changes in the professional self-definition of nursing and midwifery in relation to other professions, which led to demands for a move from apprenticeship forms of learning to 'student' based forms of learning. Each legacy leaves its imprint to be variously interpreted, taken up, or rejected by particular institutions. How this impacts at institutional level is the subject for the next chapter.

CHAPTER THREE

Institutional transition and diversity: a context for learning

Introduction

Education is centrally about processes of change purposefully encouraged. These processes take place within wider contexts of change. These two kinds of change happen in any educational institutional. One set is internal and intended, the other is external and makes a response necessary where none may have been anticipated.

It would be inappropriate to employ standardised schedules of analysis to examine the organisational context for institutions that have widely different histories, and upon which the impact of various levels of change has also been different. To understand institutional transition and diversity, it is necessary to be sensitive to the impact of local and global conditions on organisational structures, and to examine the extent to which these address needs and facilitate practice.

This chapter begins to explore the contextual changes experienced by institutions offering nursing and midwifery undergraduate programmes. It considers them from both a management and an education perspective.

3.1 Contextual factors to be considered

Contexts are not frozen in time. Nor can they be fully described in all their details. At best, the context can be said to be complex and multiply-structured by both internal and external conditions. This means that no context is the 'final' context – there is always another context which can be said to frame it.

The continuing work of people trying to make sense of the material world and each other, results in 'structures'. These 'structures' emerge from an interplay between contexts and human purposes. Gidden's (1984) uses the term 'structuration' to describe this process. Bhaskar (1993) describes it in terms of the processes of transformation. These happen as ideas are employed to unify and stabilise experience and social practice. They also happen as people and institutions respond to anomalies, conflicts, and changes in material and social circumstance. to address the failures of knowledge to represent these and provide solutions.

From this point of view, the key contextual factors that we have found useful as a framework for exploring data for a given institution include:

- **Historical context and current status:**
- **The management challenge and the politics of change:**
- **Clinical context**

3.1.1 Historical context

To understand the current context it is often useful to look at the history leading up to a given situation – in the caring professions it is essential. Institutions teaching nursing and midwifery will have experienced some or all of the following changes. Within each transition they will have worked within different organisational structures, cultures, management styles, professional values, allegiances and 'mission.'A member of staff in the institution may have been through the transitions in the following way:

NHS College Sector – In recent years numerous small, local schools of nursing and midwifery attached to NHS premises have amalgamated to form larger colleges of nursing and midwifery or colleges of health. These larger institutions cover wider geographical areas, are often multi-site or main site with satellites, and provide students with a wide range of community and institutional placements. Our imagined member of staff will have had to live with these changes. They may then have experienced subsequent amalgamation or closer affiliation with either of the following:

a) Former Polytechnic Sector – Here, degree course development has been dominated by Council for National Academic Awards (CNAA) approaches involving detailed and careful documentation for validation. In comparison to the then university sector, they were the first to promote vocational/professional degrees as a central aspect to their mission. It is currently the case that whereas the old universities dominate in the research selectivity tables, the new universities are rated highly in teaching quality. While such tables are controversial and for many highly dubious, this relative weighting towards research for the old universities and teaching for the new does echo common perceptions. Nevertheless, with research activity being an important source of income and a mark of status, all universities are making greater demands upon staff to increase their performance. Strong line-management together with faculty structures and business management/corporate ethos seem typical of the 'new' universities.

b) University Sector – The 'old' university sector, although encompassing different traditions, tends to adopt structures with a strong academic discipline base and flatter management structures. This gives considerable independence of thought and decision making to individual members of academic staff. The notion of 'academic tenure' underlies cultures of scholarship, research and teaching. For many, the loss of tenure and the rise of the market seems to spell the end of the old university ethos.

Our imagined member of staff who has experienced these institutional changes and has had to contend with university expectations and management structures, has also now to contend with other professions and departments in a large and complex school or faculty. The ethos of joining with a strong medical department is quite different from, say, joining with an education or a social work department. This ethos may well permeate the development of a given course; the relative powers and prestige of a given department may well influence the allocation of resources (See Chapter 5).

The imagined member of staff will have had to make numerous adjustments and transitions over the years, increasing their academic credentials, ensuring an active research dimension within role, becoming a negotiator with internal and external power groups, meeting curriculum design and assessment demands of different interest groups – as well as teaching, supervising, administrating and remaining *'actively engaged in practice'* (ENB 1993:2.14 par 4.2)

There are real counterparts to our imagined member of staff in all institutions. Although actual paths to merger will differ, the issues that are encountered show similarities. Pathways to amalgamation or mergers have included the following:

- The unification of several widely dispersed small colleges into a large college, was quickly followed by a merger into a faculty of a 'new' university, and an undergraduate programme was developed. Threats of redundancies, job uncertainty and changes in role specifications have affected staff. Changes in management structures and professional cultures have created increased demands for academic and research credentials of staff.

- Two colleges of nursing and midwifery joined together, one bringing an academic link with a local university due to the operation of an undergraduate programme. As a result of a regional review, the college is poised to become a faculty of the said university.

- An undergraduate programme was established between a former polytechnic and a local college of nursing and midwifery. This partnership is to be extended with the integration of another local college of health which has validation links with another local university. A range of courses will be united, including two professional pre-registration degrees.

- A partnership between an 'old' university and a college existed for two years prior to the development of the undergraduate programme. The college has increased in size with multiple amalgamations with nursing and midwifery colleges in the immediate and regional area. The college also has academic links with other HE institutions.

3.1.2 NHS reforms and markets for education

> *I think the other thing we are facing is that we are in a situation where we are part of an internal market within the NHS and the university is a social business, and departments of nursing and midwifery or schools or whatever are now being effectively run as social businesses where there are expectations of partnership issues by Trusts and other people and we are having to address marketing partnerships and think about them very*

> *differently, and that how we market undergraduate degree programmes is very, very important at the moment.*

The place of undergraduate courses within a market context is a complex one characterised by local variation and continuous change. In contrast to the arrangements for Project 2000 and pre-registration diploma students in midwifery, for instance, undergraduates are rarely included in regional contracting arrangements for newly qualified practitioners. Undergraduate courses are predominantly funded via the HEFCE, although some programmes do receive funding from the NHS via regions. Undergraduates receive personal funding, however, via Local Education Authority grants rather than NHS bursaries [1] (See Chapter 10). Some degree courses receive regional pump priming or one-off cash windfalls for specific areas of development. (See Chapter 5: Section 5.2).

The use of the market to regulate purchasing and provision of education for non-nursing/midwifery health care professionals (Department of Health 1989a; NHS Executive 1994; NHS Executive 1995a; NHS Executive 1995b) impacts on pre-registration undergraduate education. Providers of nursing and midwifery education face local competition for clinical placements.

Greater dialogue between stakeholders in nursing and midwifery education has been advocated (Department of Health 1994). Climates of threat leading to cheap short term solutions to professional education needs are clearly disadvantageous to all concerned; notions of quality are liable to be sacrificed:

> *I do feel that we are very, almost too responsive to Trusts at the moment, you know, purchasing commitments. (...) I think all the Trusts are into sabre rattling at the moment, because that's the way the market is at the moment and we get comments about (...) "Oh dear it means they are going to rush down the road, or up the road or somewhere else for their purchasing," or whether that is what the Trusts want us to perceive so we'll do more. (...) But there is a lot of pressure to put more courses on and create courses,*

> *I think the other thing is that (...) we have to be led by what they want us to do out there, and they want someone who can take bloods, stick up an IV, do all these things that we called extended roles before, and they want them now as part of basics. They want as much in there so they don't have to train anybody else – they don't have to pay out any more money. They want the person to be all singing, all dancing, when they get them at the end (...)*

The knock-on effects of reactive responses to the short term needs of purchasers have clear implications for resources and educational quality. The first lecturer quoted above must find time for speedy curriculum development (the consequence of which are outlined in Chapter 4) in addition to fulfilling existing role demands. However failure to meet the demands of purchasers is a real threat:

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[1] Students on one regionally funded programme receive a NHS student bursary

> *... if the Trusts decide that they are not getting what they want, then they will, as they have the contracts now, as they are the purchasers, they will start saying, "This is what we want."*

> *we can't afford to sit in an ivory tower and say we think they should sit here and contemplate nursing theory, or whatever, because we won't get the placements and we won't get the jobs at the end of the day*

Many Trusts see the establishment of in-house education as an increasingly real option, especially where HE providers are geographically distant:

> *... I see no reason whatsoever that consortia of Trusts 20 or 30 miles away will want to fund a course here when it is quite possible that they can set up their own, especially for things like Working Paper 10, where it is quite possible to think that you will have large travel expenses and stuff like that.*

Competitive market oriented principles are also apparent between local HE institutions. Relationships which previously operated on a basis of goodwill are increasingly being costed, and climates of competitiveness are the order of the day. One lecturer comments:

> *I would go down there and do a session if they asked me, and they would if I asked them (...) Now that, those kinds of informal mechanisms have broken down, not broken down but somebody has said, you know my Dean says to me, "If you are away from here for an hour you charge £70" because that is what the college charge us if they are away for an hour.*

Marketisation can reduce the concept of 'value' to that of 'monetary' or exchange value. Educational and professional 'values' that cannot be so reduced may well have to resist the pressure to be ignored, 'costed' (or 'proven to be cost effective'), or of income generating potential. What can be lost when this happens are the opportunities for cross fertilisation, reflection and creative exploration that have no immediate income generation outcome.

3.1.3 The management challenge

The contemporary management challenge is to service the whole range of educational and professional values within the context of marketisation. The management question is how to allocate resources to what educators, professionals and the local community value within the ever changing constraints imposed by the more global market frameworks and political demands. At a day to day pragmatic level these impact upon consciousness in terms of perceived problems, needs, demands, issues and tasks.

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Management structures for organisations must develop to meet these perceived agendas and include such key questions as:

- **How to group people to pursue activities to accomplish goals**
- **How to make things happen**
- **How to communicate**
- **How to meet changing circumstances,**

During periods of transition, within contexts that seem in continuous change and in meeting situations that seem so complex that full maps of them are impossible, organisations face the common theme of how to handle 'difference'. What is clear is that if an institution does not have a strategy for understanding and managing change, then it will be overwhelmed by its stresses and strains. One such strategy is to make an initial mapping of the situation and design courses of action to move from the conditions described by that map to the planning of new operational environments. This is effectively an educational perspective applied to management.

3.1.4 Managing the politics of change: identifying the problem structure

As may be expected, institutional amalgamations have not led to straightforward syntheses of management structures, cultures and practices. Many institutions are still in the process of evolving structures in a 'boot strap' fashion. As they do so they learn to live within or move towards one of three possible forms of amalgamation:

- **Unitary synthesis** – negotiation and accommodation
- **Revolutionary replacement** – 're-education'
- **Syntheses** that result not in a unitary form but a **plurality** of localised organisations

Since the politics associated with each kind are quite different, then the strategies of response and the demands on institutional learning will also be different.

Unitary synthesis requires educational management structures that favour dialogue to identify the 'stakeholders' served by the institution, their interests, agendas of issues of contention between them, alternative viewpoints regarding their solution. The key distinguishing feature of this approach is that it seeks to create the structures for consensus concerning philosophy, purpose and forms of action. Its danger would be that consensus is achieved at the expense of compromising values.

The second – revolutionary replacement – taken to its logical extreme, replaces the processes of education and learning required by the transition by simply replacing the staff who have 'old' views, with those who have the 'new' views. If such physical replacement of staff proves impossible then the courses of action that open up are either coercion, or re-education, or both. Coercion can be applied through the use of surveillance strategies and performance criteria under the name of quality control. Re-education can take place through the kinds of 'professional development' which tell rather than discuss, debate, critically analyse or leave open a range of alternatives from which the professional is able to choose.

The third – a plurality of localised syntheses – can be seen in the devolution of decision making from the centre to teams at the periphery. Educational processes become focused upon informing decision making for team/individual practice to meet local conditions. While the strength is the fit between team practice and local conditions, the weakness can easily be the fragmentation of a large system into many small, unrelated groupings that constantly change as local circumstances change. The educational response to this would be to develop dialogic structures that facilitate exploration of what is common, what can be learnt, and how to co-ordinate actions to meet broader concerns at increasingly globalised levels of action and concern. This does not demand total consensus throughout a system and hence may provide a means of avoiding compromise positions while also meeting the need for co-ordination to deal with complex local and global problems.

In sociological terminology the above three approaches are 'ideal types'. That is, they point to the essential features of a particular idea, phenomenon, or category. Ideal types do not exist in reality in a pure state. They provide a means of thinking about actual cases and the implications of taking one approach rather than another. In actuality, any institution faces a political problem structure that typically includes:

- **learning about change**
- **employment issues**
- **professional development**
- **occupational culture**

The ideal types described above can help in thinking through what is at issue and at stake when an institution chooses one set of approaches rather than another set. Any such choice demands educational responses, and in particular, an understanding of the learning process at every level from the personal to the institutional.

3.2 Learning about change and the impact of institutional mergers

Learning is characterised by the 'grasp' of underlying patterns. The process of 'getting a grasp' begins in the question, 'What is going on?' It is a search for some unifying principle which will describe what is happening in such a way that it explains, even predicts what will happen next. The ability to explain and predict has implications for the sense of empowerment.

In the case of amalgamating institutions where the history and extent of any former relationships have encouraged a sense of mutual understanding and a sense of continuity and empowerment, then optimism is likely to be high:

> *We've had a very close relationship with the college, it goes back to the early 80's and in some senses I think we've an exceptional relationship because it is so long standing. I mean we've been delivering programmes jointly together (...) over the last 15 years, so it isn't actually a shotgun marriage as so often these things are so we have got to know staff well ... and obviously we've got conjoint validation for the diploma programmes. (...) and I think considerably more than a paper relationship, we've got teaching on both programmes which we work on a financial basis between the college and ourselves and er, I think we're er probably as close to integration without being merged as anyone in the country really.*

At the other extreme to those institutions which have experienced close collaboration over many years are those which have had imposed on them periods of uncertainty caused by regional reviews of educational provision. Such reviews invite HE institutions to tender for the educational activities of NHS colleges, determining which institutional amalgamations can proceed and whether existing links are to be maintained or new links forged. Some of these reviews have been protracted and not all have heralded pathways as positive as the one suggested above. Uncertainty, perhaps discontinuity, even fragmentation have been the experiences of these latter:

> *... we get the information so late, we only heard very recently that we were definitely going to be incorporated into the university, the region definitely agreed it, that was just before Easter, (...) it's a very sensitive time for everybody.*

There is a felt distance from an important scene of action and of decision making. The image is of discrete levels with their own circuits of communication.

> *An options appraisal was done some time ago by an independent consultant who looked at three universities and made the strong recommendation that we link with Newtown University, for all sorts of reasons, the university takes a lot of health care professionals for undergraduate programmes. (...) That was all set for April and then region suddenly put a hold and said it wanted to look to rationalise what was going on in the region and no incorporations were to move forward. So we had to put it all on hold, which again was unsettling for the students and for us and for everybody, and another options appraisal was done, and again the same result came up which is good really because it makes us feel this is a good decision...for us it always felt like the right decision (...) that was the decision that was made, but we won't be able to incorporate until October now because of that hold time.*

For this lecturer there was the sense of decisions being made elsewhere, of competing external agendas that delay action. In a competitive arena where decisions are made elsewhere, planning can only be provisional:

> *... educational provision (at the college) is either being broken up or different institutions are tendering for different parts, so we have tendered*

> *for the nursing and midwifery parts. (...) The tender documents I think go in at the end of this month, the results of that won't be known until the spring, so if we get, if what comes out of that is an appropriate synergy, then I think I'm very positive. If it doesn't, if another institution gets it, well I think this course will stop.*

The impact of external changes can be experienced along axes representing degrees of continuity or discontinuity on the one hand and empowerment and disempowerment on the other; students, lecturers, courses and resources may be vulnerable:

> *...for my group (of students) it has been a difficult time, we were starting in one place and moving to another and then also seeing quite a few changes which I don't know whether they necessarily understand or whether we necessarily understand all of the changes, or who's a senior lecturer, nurse tutor (...) and on and on and on and on.*

The result of a change decided upon at one level affects other levels. What seemed rational at one level may lead to de-skilling and incomprehension at another. Such change needs people who have faith in it, who can transform its unsettling nature into a vision of progress, of future benefits:

> *... instead of having a tight knit group of people that organise the degree course, they will be by definition split up – that might not necessarily be a bad thing, but it's going to be a challenge and a change. In the long run it's obviously going to be beneficial because we will have the resources of a whole school, as opposed to the under-resourced degree programme, so in the long term it will be of benefit, I have no doubt whatsoever, but in the short term it's going to be difficult to try and maintain a degree ethos in a school, the bulk of which is conditioned on diploma level. The other thing that we have got to make sure of is that the students, who are used to a degree (...) don't get lost from moving from one establishment to another. It's quite possible that they can loose their roots and therefore we have got to be very careful that we actually do keep some form of identity for them.*

This individual has an understanding of aspects of the cultural problem structure that unfolds as the changes are implemented: maintaining the degree ethos, ensuring students do not loose their identity. Another dimension of this problem structure is that of relationships with clinical partners. The senior Trust nurse quoted below identifies a series of managerial, philosophical and geographical shifts which have created hairline fractures in once close partnerships:

> *What's happening is that education is being gradually moved away from the clinical situation and we're getting a separation of, instead of the integration of training and service side, there's beginning to be a little fence built between them (...) the other curriculums for the P2000 and everything else were run by the college., when that developed that took education a little bit out of the service area. And this year the college is*

> *integrating with the university. And when that integration takes place I can see that again they'll become more divorced from the practical side of things as well. A bit like a medical school. We're educating them and we'll be lucky of we see the teachers and the tutors on the ward.*

The fences between education and clinical practice seem in this view to be reinforced by the changes. This has implications for the quality of professional education and for resource provision to sustain the structures, mechanisms and procedures required to repair such a split.

3.2.1 Faculty/departmental/school structures

The impact of mergers upon the internal organisation of a department can be dramatic:

> *... it just developed too quickly from being a college to a polytechnic to a university, it's been too rapid an expansion because not only they increased the, obviously the level of the courses (...) everything has been rapidly changing and so it's grown to my mind too quickly because there's no real infrastructure and this sudden amalgamation on one site ... literally (...) people from diverse backgrounds from a handful of institutions, all with different philosophies and traditions. Obviously it's going to cause quite a time before it settles down again.*

Change necessarily involves the need to learn how to handle transitions, avoid dangers and profit from opportunities. That learning has to be structured into the organisation itself, otherwise it risks being dissipated or transformed into in-fighting and strategies of resistance.

From TYDE interviews an image emerges of layers of activities, some hidden, running in different directions, running towards uncertain futures and of a growth so rapid that the complexity cannot be fully comprehended. It is a process that seems for some to have no end, particularly within the context of an expanding university system:

> *It's not been about less jobs, it's only in this latest integration that there has been some shake out with the integration of the college of nursing, but what it's been about really is the rapid expansion of the university really, and that has involved quite a lot of restructuring in the process (...) So the whole thing was like being in a bit of quicksand really.*

There is a kind of breathlessness, a loss of control, an inability to get the whole story or see the whole picture:

> *There's now a process of gradual misinformation, loss or whatever as we go through one reorganisation to the next.*

> *... there's no permanence, that we're in a feeling again of transition and that things are not being told us. It's the usual sort of streak of paranoia when all is changing around you that you're not being told the real story.*

> *(...) the game plan and you're a pawn in a greater game and so on. That's personal feelings, and a lot of people sort of express that fear because everyone recognises that nurse education is at a very important cross-roads (...) there's all this uncertainly really that is bubbling below the surface.*
>
> *I'm confused by the confusion now.*

A key question for management is how to generate structures able to encompass the increase in complexity brought by growth, merger and changing external relationships and expectations:

> *... it's such an enormous department. We need a slightly less flattened management. We have a very flattened management and actually most of the time the only people to give you support are your peers and sometimes you need a manager, and that's very difficult when there's only one. (...I'm) quite happy to manage my own work, 52 weeks of the year – just the odd day, I think I could do with a boss to say to me, "No, no, no, you're getting into to much," or, "You need to do this," or, "Why are you doing that?"*

The argument often advanced for a flattened management is that structures evolve to meet the needs of the organisation operating within rapidly changing contexts. The flattened management structure pushes decision making downward to the individual who is closest to the action. However, as problems and demands multiply, individuals can become overwhelmed, feeling torn between the competing demands.

The plea for a little hierarchy as a solution may only address part of the issue. It may be that an additional layer of management may solve problems to do with 'what to drop and what to take on' but this does not make the problems disappear. Flattened management structures may well disguise the enormous range and quantities of work undertaken by staff. This suggests a flattened hierarchy may be as exploitative as it is empowering if employed as a strategy for not hiring levels of staff adequate to the demands of work. A flattened hierarchy requires resourcing if it is to work as a flexible response to fast changing situations.

At the other extreme is imposed management:

> *When I moved to the college the lecturer in charge there had quite a different management style as it were and it was definitely bottom up and not top down, everything was discussed in open meetings and, "How shall we go forward in what we do?" And, "This is what we are planning." (...) Whereas it's quite clear here that it's top down (...) it's a feeling of umm, you know, change is dictated, is directed rather than being organic in the sense of developing.*

The advantage of 'imposed' management is that change can be implemented fast and some of the anxieties associated with uncertain futures avoided:

> *Although we've been through this fairly traumatic integration, it was very much a top down imposition, I think it's thrown us together in a way that maybe we wouldn't have had if it had been a long protracted process. So it's actually built in a lot of support networks, and seems to be fairly successful.*

There is a need for clear management which is appropriate to the decisions and actions that have to be made, and which takes into account the requirements for staff support. In one institution which developed a large faculty structure split across multiple sites, strict line management led to a kind of decision paralysis as days and even weeks went by with information slowly finding its way up and down the structures. In some places this is called 'consultation' and is combined with meetings:

> *... there has been lots of consultation with the staff, what kind of benefits we've got from it I'm not certain. A lot of repeat information has been said, we've had meetings and more meetings. (...) I personally don't think they've had much success but then you know, the management will probably tell you otherwise.*

Rather than being facilitative, management becomes the 'other', the obstacle preventing professional activity:

> *... there's lots of communication, there's too much communication, nothing gets done. Look, this is why my desk's like this, I get memoed from everyone, there are meetings about meetings.*

This is not real communication. It takes the place of communication. It leaves an 'audit trail' as evidence that the staff have been 'informed'. To be successful, there has to be dialogue between all the levels of the department/faculty, between the department and the rest of the university, and between the department/university and its clinical areas and their managing Trusts. The task is how to ensure that dialogue becomes an agency of structuration.

If an organisation is to change and develop in ways which are appropriate to its context and purposes then it aspires to being a 'learning institution'. In particular, it aspires to be able to sustain continual, creative critique. Education is thus a second key principle underlying structuration. Like dialogue, it is necessary but not sufficient unless it includes principles for decision and action. This requires processes of formative evaluation. The principles of dialogue, education, and evaluation are at the heart of debates about the relation between academic and professional values and are revealed quite starkly through employment issues.

3.2.3 Employment issues

Organisations distribute values, and these reveal themselves crucially in terms of employment issues. Everything depends upon the way in which staff are valued. Where education talks of enabling individuals to reach their potential, market discourses talk of the economies of scale and mass production that can result from standardisation.

Examples of the displacement of debate from the development of and care for individuals into negotiations about economies of scale can be seen where institutional amalgamations have coincided with reductions in student numbers. Many institutions report recent declines in the numbers of pre-registration nursing students on diploma level courses, and the cost equation between staff and students is clear:

> *... because student numbers go down, staff numbers go down, now there's a big question over whether those redundancies happen before amalgamation or after amalgamation, who bears the cost of those redundancies?*

Amalgamations and rationalisation are not only a matter of economics, but of careers and effects upon personal lives. Irrespective of the approaches used, where staffing complements have been reduced, the consequences are felt by all:

> *Well it was a very traumatic time, very traumatic and I think the effects of that will be around nationally – as it has happened everywhere – for a long, long time. I think it has been traumatic. I must say it was very well handled here and very professionally managed, but who would have thought 20 years ago that we would be making nurse tutors redundant. It has been traumatic and the people who remain feel bereaved, they have lost colleagues who were valued and part of a team. And obviously for people who were made redundant it was traumatic although they received counselling for re-employment. But that's not the point – it was a very difficult thing.*

In some circumstances staff do not feel like people but commodities in a changing system:

> *I mean I speak as a personal thing (...) when someone said to me, "You're lucky to have a job," then I just blew my top and said well, you know, "This is not what I'm in this game for, to be lucky to have a job, whatever that means." Umm so I think a lot of people are quite demoralised, certainly I am personally. (...) To put it in a nutshell, you're being treated as a commodity (...) this is purely my feeling (...) the commoditisation of nurse education and that's an overwhelming feeling, that we are being packaged in various ways, sort of being manipulated, being selective and, you fit and "You don't fit", and this sort of process that's been going on. So yes, it's demoralising and it's, obviously there's a lack of dignity and loss of quite err, self esteem and quite a few things that go with that.*

There is a sense of social injustice which creates the potential for resentment.

The nature of employment is changing as fast in nursing and midwifery education as it is for the work force generally. Short term contracts, probationary periods and few guarantees are replacing notions of security and 'jobs for life'.

> *There seems to be from what I've read, two models, one of which is spill the blood then merge; the other is spill the blood after the merge. I think there is possibly a third way which, our, the new Head (...) has managed to negotiate, which is a gradual anticipatory slimming down, so people have not been replaced and new people when they arrive realise that they are on short term contracts so that they know, they have been employed on the understanding that they will not be here for ever, they know they are on a one year contract, or a two year contract or a three year and then it will cease. There is a possibility that it will be renewed, but they are not anticipating that they will be here forever. (...) Ours will be I think, merge and then the people that are on short term contracts will slowly just disappear and will be able to I suppose the word is now, it used to be downsize and I think it is now rightsize, without the traumas that some places have been through. Now to me this means it's been very well managed, and I think the fact that we have taken our time about the merger has actually helped that. I know some people have leapt across very quickly and it has been very nasty. There are some places around that will take years to recover from the wholesale slaughter that's been going on. But I think here it's been managed differently.*

The pressures associated with decreased job security are clear. In one department where a number of junior staff were all on probation, a lecturer describes the situations as follows:

> *But it's this sort of continual pressure that people feel. Staff are under a lot of pressure, a lot of people here at the moment who are on three year probation (...) they feel under tremendous pressure because they are trying to give quality in every sense of the word, you know, the teaching, the research and publications and they just can't do it. Certainly not, well not easily, you've got to be a workaholic and you've got to want no life external to the university in order to succeed really, or else you just don't deliver the standard you want to deliver. Something has to give.*

Moving onto new contracts has been a protracted process for staff in certain institutions. Some staff have waited years for new contracts:

> *... quite a few of us don't have contracts (...) because the funding hasn't been sorted out basically. We have been talking about it for years. I mean to be fair to the university there was a large number of people who had real difficulties about moving contracts to begin with, and the initial reluctance was not from the universities point of view, it was actually from the lecturers point of view (...) they were unhappy about the conditions of service and they were unhappy about pensions and things of that kind.*

> *The initial offer of contract offered a lower salary than people were already on, so there was a dispute about that.*
>
> *... this is a very complicated political situation I think rather than anything else, it was quite clear that when the merger arrived the university did not want to take everybody overnight and say, "That's it, you're senior lecturers," for various reasons as I understand it, one is the sheer number of them and two is because I think it felt that quite a few of them haven't really got the required qualifications and they wouldn't have employed them anyway. So there was this hybrid situation.*

Others are still waiting and continue to be employed on old style NHS contracts:

> *... there were quite limited opportunities for people to move from their held NHS tutor grade to umm a university appointment and all that goes with that (...) there's not any scholarly activity time for instance, that's a good example.*
>
> *I have less holiday than a senior lecturer and less study leave than a senior lecturer. The senior lecturer has five weeks study leave, maybe more. I get two weeks study leave plus another week that I can negotiate for management time or I can turn that into study leave which I have been allowed to do. (...) I can't remember exactly how much annual leave a senior lecturer has but I think you're talking about another ten days more, I think. Umm, and there are other things that senior lecturers can do and nurse tutors can't do. We're still an odd breed within the university, and some people felt quiet discriminated about it.*

Some of the considerable pressure experienced by many staff derives from external influences which the institution cannot control. However, there are factors that do come within its sphere of influence. These are a) staff support and professional development structures, b) communication, c) the clear definition of roles and d) the provision of information in a climate of openness.

3.3 Occupational cultures: the changing context of academic and professional values

Since organisations distribute values and allocate resources in accordance with that distribution, the ways in which organisations reach decisions about values is thus critical. Organisations are not homogenous hence there may be disputes about values. The recent period of rapid institutional merger and professional developments may come to be regarded as simply a temporary transitionary period from one relatively stable 'status quo' to another. However, the pace of technological and political change at global and local levels show no signs of slowing. It may be what is described in the following sections is a permanent condition for the foreseeable future.

3.3.1 Uniting cultures within higher education

Education for nursing and midwifery is a meeting point for a complex of professions and 'sub-professions' that have evolved their contemporary form, largely over the last fifty years. If these cultures are to co-exist beneficially, management structures within changing institutions must address issues of cultural development:

> *... it creates some problems in terms of culture, in terms of the culture that we have here which we do value, umm, we feel could be swamped by the culture of the college of nursing which would seem to be very, very different, they seem to be much more hierarchical and... boring and quite rigid.(...) What you have in higher (education) institutions is that the relationships and organisations are based on trust, whereas I think in nursing the culture is very much spotting people who are not doing their job properly.*

The issue of cultural development probably has no stable end point. The management and academic distinction overlays older discourses of workplace cultures and of vocations as both pre-registration and post registration education move towards a more academic grounding.

> *I think the whole management structure of the existing colleges of nursing is not inculcated within the university culture, whereas a university lecturer, as you know, has considerable freedom as to when they work and what they do. I would not know where my staff are at any one time. I don't need to know, because if they are confident enough to be a university lecturer, they don't need a head of department knowing where they are. (...) Now the culture of the college of nursing is very much hierarchical, devolved through different grades, different structures. Bringing that culture into a university culture is going to be difficult.*

Here the cultures of practice meet the academic cultures of the university sector, with its focus on research as well as teaching. What is interesting is the way in which the different cultures 'position' each other and have different organisational implications. From one point of view academic cultures may place practice cultures into a subordinate position; from the practice point of view this may be entirely reversed. Taking now a management position, both academic and practice cultures may be seen as objects to be managed in the interests of the production of 'profit', 'efficiency', 'cost-effectiveness', and the meeting of politically identified 'performance criteria'. Such a strategy of positioning based upon hierarchies of cultures inhibits the possibility of a dialogue which would lead to creative syntheses of cultural values and the distribution of resources to meet those values.

3.3.2 Competing priorities in the new university sector

In the new university sector, there is increasing tension between the activities of teaching, research and clinical practice. The pressure to gain and develop a research profile in the case of former colleges and polytechnics, and to maintain and improve existing ones in the case of 'old' universities are acute.

Nursing and midwifery research are relative newcomers to the body of more established research traditions in other disciplines. The results of the HEFC Research Assessment Exercise (RAE) of 1992 provide painful evidence of this as 'nursing[2]' achieved the lowest rating in comparison with other the 72 other subjects (Times Higher Education Supplement 1992a). For the RAE, panels of academic specialists in each subject are involved in grading research on a five point scale of excellence from '5' indicating "some research of international excellence with the rest of national excellence," to '1' indicating "research of national excellence in none, or virtually none of the areas" (Times Higher Education Supplement 1992b.)

Of the 29 'nursing' departments participating in the 1992 RAE, seventeen departments achieved a ranking of '1', seven a ranking of '2', two a ranking of 3 and the highest achievers awarded rankings of '4' were three 'nursing' departments all located in 'old' universities. No nursing departments achieved the top award of '5' (Times Higher Education Supplement 1992a). The percentage of academic staff engaged in research within departments was also taken into account in the research rankings, and results for 'nursing' again showed considerable variation between departments.

Understanding the process of the RAE was indeed very difficult for staff in many institutions, particularly in the former polytechnics and new midwifery and nursing departments in 'old' universities encountering the RAE for the first time. As Robinson (1993) comments, "*...participants have had to become familiar with a system of increasingly Byzantine complexity and a feeling like Alice in Wonderland in terms of changing goal posts.*" Such struggles are echoed by academic staff, with one lecturer in a former polytechnic describes her experience thus:

> *... we've just gone through it for the first time and having gone through it, I'm still not completely clear on what criteria these decisions are made ...*

For many nursing/midwifery departments in former polytechnics or newly established departments throughout the new university sector, developing research expertise and a profile of recognised activity is a major challenge. The need to develop departmental research strategies, research skills and cultures of confidence is clear:

> *... to me the whole point of the merger is actually increasing the general awareness of the importance of research and in the long term therefore increasing what is done. But I think that's got to be a gradual thing and you could break people. I mean you're got to do it gradually, you've really got to.*

> *... there isn't any midwifery education research going on and there isn't a research department within the college and that is a definite must for any*

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[2] The term 'nursing' is used in the Research Assessment Exercise in a generic sense, including nursing, midwifery and health visiting.

> *move into higher education. I mean...I think the ethos of the university where everybody is doing research or that seems to be the situation is good, but I think we've got to be a little bit careful with about how much research we're subjecting the women (to) in the clinical areas, so I think it's got to be controlled to some extent.*

The pressure to increase institutional research performance is a strong one, common to all institutions in the new university sector. During the TYDE Project staff at participating institutions do report progress in research activity, however there is recognition of a need to proceed at a pace which is realistic for each individual institution and the resources available to it. Establishing a firm basis from which to develop a research profile is vital, with staff appointments and start up income.

> *... we have just moved towards a research strategy for our school and we are trying to balance our inexperience with doing research with the drive that's coming from above to do it, and the lack of resources to pump prime. What we don't want to happen is that we take on board research just because it we are dictated to that we need to improve our academic research rating. We accept that, and we are aware that we have to whether or not we want to. But we want to take it on board from developing our strengths, what we've got to offer, so we've gone through an exercise of identifying where our main areas of (...) research strength lie, the methodology we want to use and the approach. And I think in the initial stages we might want to see the staff development part as being crucial to that process ...*

> *Well one of the things that I feel is happening is that people think that there's more to research than meets the eye, right. Now yes there is, I mean when you're doing a PhD it becomes immensely complicated but I think people are quite frightened of research, a lot of my colleagues as well.*

Nevertheless, pressures on individual lecturers to combine research, teaching and practice activities are evident in much of the TYDE data:

> *... there's a culture at the moment in the department around...teaching is not valued, all the pressure is now on research because (of) the selectivity exercise and we don't value teaching. (...) How I think that needs to be looked at is in the past we have over valued teaching and we have undervalued research and, "Why work in the university if you don't want to do research?" So what we've, what we've got to do is not, like devalue teaching but alter the balance.*

> *And of course we're in competition over the RAE with everybody else, where nursing did so abysmally, but not surprisingly, and there's the double speak in the University about, "Yes thou shall come up with the best RAE results because we want to be in the top ten, but thou shallot also take teaching extremely seriously and make student centred," et cetera So*

> *that's a tension. There's the tension of practice, of the relationships with the practice areas where most people would like – not everybody, and I think that's important- would like to have some practice base.*
>
> *... unlike some nursing studies departments we see our raison d'être as clinical practice, and people can be quite critical of our research and our research (...) – I offer no apology – is very firmly client focused. We are surrounded by other clinical areas. So we have endeavoured to become entrepreneurial in innovation in nursing. (...)We feel obviously that enriches our students, they learn very early that a university lecturer is someone who is involved in the practice of nursing and midwifery. And hopefully they benefit from our research, through our publications, through the books that we publish. Really I guess we're only just beginning to reach that level of staff numbers where we can be more pro-active really if you like, in tackling some of the problems out there in clinical areas. And we really wouldn't want to detract from that.*

Each faculty or department is unique in its activities. Often mixed economies are used as a basis to generate income according to perceived strengths, whilst at the same time being responsive to trends in order to ensure survival in competitive markets. Such directions, visions and values may not always accord with personal aspirations, and the conflicting pressures which some staff face are clearly experienced as problematic:

> *To try and deliver a really excellent standard of teaching and to really give to the students, which was what I was really committed to, I mean I would give them anything, but it's just not valued, it's a complete waste of time (...) and this is what they mean when they talk about value, the value is on research and publications and if you care about students, well forget it. It's not that the people are deliberately horrible, it's just that they are true academics around this place, they are totally, bloody selfish. And you know, they are into their own careers and furthering that (...) ...there were more pure academics when I first came here and there are less academics, people who have come from colleges where there's a more perhaps caring environment, but then they are knocked because they are not academic enough. So it really is a no win situation. I mean we muddle through, it sounds very negative this, doesn't it?*

In addition to teaching and research commitments and generally demanding roles, lecturers have a clinical component to their work, which ranges from a liaison role involving regular support of students and clinical staff (who in actuality are responsible for developing students' clinical learning), to joint appointments held with clinical areas or clinically based research remits. These issues are considered in more detail later in the report, however an exploration of academic and professional tensions affecting education staff would not be complete without mentioning the issue of clinical roles which many lectures would like to see placed higher on agendas of competing activities:

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> *... I don't think it is a misconception by the university, I think it is more the other way around in that the faculty, a new faculty in a university, felt it had to comply with the university and perhaps sold us short in terms of it didn't really argue that (...) teaching in clinical practice was as valid as teaching (in HE) because they felt that we had to do a specified number of contact hours and that (clinical teaching) was over and above it. I think now people are beginning to realise it is, you know, actually quite a lot of teaching.*

The discussion to this point has turned around a series of binary oppositions typically employed by people when they recount their experiences. There is a need for a theory of knowledge that resolves the 'theory-practice-management-research' gaps implicit in all the binary oppositions held in place by the most common cultural oppositions and management structures.

3.4 Summary

There is an overriding sense that developing deep understandings of the undergraduate programmes is not a simplistic task, as each degree is embedded in its own unique history, and exists within a context that is continually changing. The multiplicity of educational and professional cultures in which the variety of degrees operate causes us to question what constitutes a degree. It is clear too, that the difficulty of collecting a suitably large evidence base on which judgements can be made becomes more difficult during continued periods of transition.

Key factors affecting the context in which degrees in nursing and midwifery are designed and operated are as follows:

- marketisation of nursing and midwifery education and climates of increased competition between educational providers;
- institutional mergers and amalgamations of HE and NHS colleges of nursing and midwifery or health, creating new departments or faculties of nursing and/or midwifery which require:
    - new visions and directions which are collectively and collaboratively developed;
    - the creation of management approaches which unite cultures, combining the professional and the academic in equal partnerships;
    - identification of new problem structures, and the need for new problem solving strategies.

The institutions which participated in the evaluation were and are at various stages of progression along the continuum towards mergers and integrations. Periods of transition have been reported as provoking anxiety and uncertainty for midwifery and nursing lecturers, particularly in relation to job security and role change. Institutional management strategies profoundly affect levels of personal health and professional performance during these transition periods.

It is in this context that pre-registration degrees attempt the substantial tasks of designing and operating professional curricula.

PART TWO

The voice of experience

CHAPTER FOUR

Planning the professional curriculum

Introduction

Nurses and midwives require an education which will prepare them to work in a rapidly changing end of millennium world. Right from their inception, degree programmes in nursing were constructed with the intention of facilitating the development of patient focused, holistic practice, underpinned by enquiry (Chapman 1975; Clarke 1981; Altschul 1987). This culture persisted in the subsequent development of undergraduate level nursing and midwifery education. Graduate practitioners, it is argued, will be able to 'deliver' care *and* co-ordinate it in new and as yet unknowable contexts. They will, by virtue of having had a higher education, be people capable of informed critical thought, and therefore able to lead planning for a range of alternative scenarios. It is anticipated that the level, breadth and depth of knowledge will inform clinical practice, creating safe, effective, reflective and flexible practitioners.

Since the late 1980's, nursing and midwifery education has been radically reviewed with the introduction of Project 2000 (UKCC 1986) and pre-registration midwifery. There has been continued debate on the nature of nursing and midwifery education, and how this vision is to be facilitated in light of changing health care services (Department of Health 1989b; NHS Management Executive 1993; Department of Health 1994; Nursing Strategy Workshop 'Health and Social Care 2010 – Shaping the Future' 1994; ENB 1995b; Royal College of Nursing 1995). The roles of nurses and midwives are also being influenced by reviews of inter- and intra- professional boundaries in the form of the UKCC's Scope of Professional Practice (UKCC 1992), the introduction of Health Care Assistants via National Vocational Qualifications, and the reduction in junior doctors hours (NHS Management Executive 1991). Concurrently, new demands for post-registration education have appeared in the form of the UKCC's PREP requirements (UKCC 1991). There has also been an explosion in the provision of post-registration education available in terms of range, focus, academic level and modes of study, to meet the changing demands made of midwifery and nursing practitioners

This raises three questions for pre-registration undergraduate education in nursing and midwifery. Firstly, what kind of curricula, in particular professional curricula, are required? Secondly, what are the management structures and mechanisms appropriate to the implementation of this aspiration for any course? And thirdly, are the current structures and mechanisms of specific courses appropriate to the task of promoting their particular declared 'educational' and 'professional' aspirations?

The data in this chapter provides a picture of how many people have experienced the crucial stage of planning a curriculum.

4.1 Aspirations and actuality in professional degrees: the curriculum problem

In designing curricula for degree programmes, it is possible to take for granted the relationship between degree level education and flexible thinking.

> .. *(the degree programme) involves a high level of decision-making, reflection, critical awareness and evaluative activity. The effectiveness of nursing practice can be developed through systematic, purposeful and creative activity, critical thinking, and logical and intuitive judgement, based on empirical, aesthetic, moral and practical knowledge.*

New undergraduate curricula may be designed in which the university rhetoric about critical reflection on knowledge is foregrounded, and for which the aspiration has been that students be encouraged to explore the world of their 'discipline' by contemplating alternative worlds. Expectations are therefore exceptionally high.

One of the aims of nursing and midwifery undergraduate programmes is to develop flexible thinkers able to contemplate alternatives. It would be reasonable to expect that thinking through the curricular structures necessary to support this aspiration should not be hurried. Groups of staff in some institutions have years of expertise to draw on when developing undergraduate programmes; for others it is a first attempt at a new academic level. Time and human resources for curriculum development vary enormously (See 4.4.2 below).

Where courses are designed at short notice, planners are unable to find the space to reflect on what it is they are producing. Time for reflection may also be limited when living with the consequences of rapid programme development and implementation. One consequence of short lead-in times may be the production of highly generalised documents in which the structures for making things happen are under-specified. Other consequences include content specifications which are over ambitious, or which on implementation do not lead to the degree of integration of learning initially anticipated.

Where programmes are operationalised in conditions which discourage movement towards the educational 'ideal', unsurprisingly the ideal is never achieved. In meeting bureaucratic demands for the rapid production of new curricula, curriculum designers may be obliged to answer management questions before educational ones. Curriculum documents prepared for validation purposes may juxtapose ambitious educational rhetoric with structures designed primarily to satisfy external bureaucratic demands. The first aims to enable students to contemplate multiple perspectives and complexity, while the latter deals with management's requirement for simplicity. One encourages openness, the other closure.

4.2 An emergent model of the professional and of professional spheres of action

Undergraduate nursing and midwifery degrees have to be able to satisfy two key criteria; they must operate at an acceptable academic level, and must guarantee sufficient learning in practice for students to be able to qualify as competent to enter the relevant part of the professional register.

A curriculum document is essentially a plan which is intended to address a particular learning problem structure. Nursing and midwifery documents broadly explore a set of common themes, values and issues, as illustrated in the following examples:

> *The graduate nurse must be able to deliver care on an equal basis to all, whilst taking into account individual requirements and particular cultural backgrounds. The nurse needs to develop an understanding of the social, psychological and cultural factors associated with the needs of patients. This has been taken account of in designing the curriculum and particular attention has been paid to the application of nursing theories to practice.*
>
> *Midwifery care must be a dynamic process in order to cope with the changing needs of clients and with the changing environment of childbearing and midwifery practice. The emphasis on learning skills, the encouragement of debate and the focus on current issues and controversies helps to foster the dynamism of professional midwifery.*
>
> *The common currency of pre and post registered nursing is the belief in the intrinsic worth of the individual. This applies equally to course consumers and to the patients and clients whom they serve. Nursing is seen as a facilitative and proactive activity which enables individuals of groups to adapt to various demands upon their health. The nurse promotes independence and self care where this is appropriate taking into consideration the total health needs of the individual.*

Undergraduate curricula also aim to promote flexibility and responsiveness to changing health and social patterns. They do so by encouraging student midwives and nurses to re-examine their prospective roles:

> *Both the cultural and social contexts of contemporary midwifery are addressed in this (educational) model and this reflects changing expectations with regard to the role of the midwife in today's society. The model acknowledges the rapidly changing nature of contemporary British society, in particular, family forms and patterns of childbirth and identifies its significance for midwifery.*
>
> *We believe that it is necessary for nurses to understand and influence the place of nursing in a contemporary, changing perspective, based upon a broader context of what is happening in contemporary society and health in particular, in order to provide quality individual care.*

The distinct professional identities of nurses and midwives are also emphasised in curricula, in relation to each other and to other health care professionals:

> *Nurses are part of a social and health care system, which fundamentally influences the nature if their role, their work and that of others, for example the work of nursing belongs in a wider framework of women's work in the labour market and*

> *must be seen against a background of diverse ideas and perspectives which shape public policy agenda (sic) for health and nursing.*
>
> *Pre-registration midwifery programmes are a considered response to the desire for a re-emergence of a distinct professional identity of the midwife in the UK which was gradually eroded following the passing of the midwives act 1902 by entry of nurses into the profession, and the gradual reduction in the proportion of singly qualified midwives.*

In the case of midwifery, a distinct professional identity which sets it apart from nursing, rather than as an 'add on' has been strengthened by the endorsement of the pre-registration educational route. This stance does not exclude the premise that elements of shared learning with nursing or other related professions can bring mutual benefits:

> *(The curriculum) should also demonstrate the dynamic relationship between the nursing and midwifery professions. This relationship has evolved from the belief that shared learning "within the context of profession-specific, professional practice" (UKCC Registrar's letter 28/1992) increases the level of understanding, the scope of collaboration and co-operation between professionals in the delivery of care.*

The curriculum documentation, then, provides an indication of what is seen as characterising a 'professional'. It also offers evidence of the perceived relationship between professionals and their associated contexts of action. Diagramatically, this may be shown as follows:

SELF

transition to professional identity

values:
- holistic care
- intrinsic worth of self and others
- reflective practice
- critical
- learning

proactive

autonomous

confident

flexible

assertive

OTHER

changing needs of client

family

friendship groups

communities

other professionals:
- shared learning
- decision making
- joint action

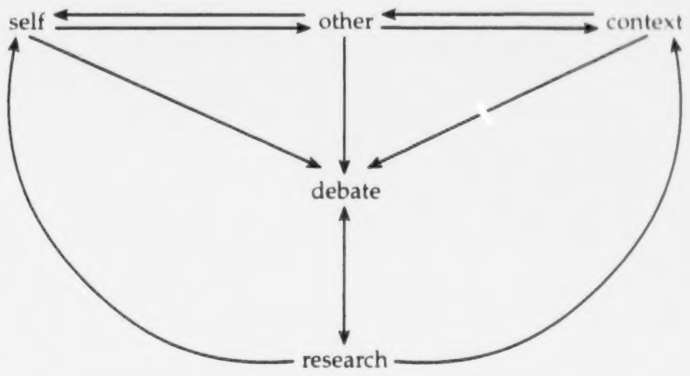
Them:
- the System
- the Government
- the Management
- etc

CONTEXT

cultures (s):
  discourses
  change:
- multi-layered
- multiple sites
- social patterns

source of multiple demands:
- health care system
- public policy
- market
- 'women's work'
- etc

A simple model of the relationship between these categories might be constructed as follows:



There is an obvious association of ideas here with the reflective practice cycles of Schon (1987) or the action research cycles of Elliott (1991). What is different is the more specific explication of relationships to self, other and context and to the reflective relationships between research and debate.

In trying to describe the knowledge bases of nursing and midwifery, curriculum documents typically point to both the unique perspectives and their contributory disciplines:

> *Nursing is a scientific art, interpersonal and caring in its attempts to support and nurture the individual and the wider community. The art of nursing has strong foundations in the physical sciences, behavioural sciences and humanities, thus its practice requires a formal education and research base in the discipline of nursing and related bio-psycho-social disciplines.*

This document is typical of several which identify sources for the professional knowledge base with the implication that the 'art' of nursing/midwifery can be drawn by the professional into some picture of the practice of nursing/midwifery. Questions could be asked about whether these contributory disciplines are set into debate with each other in terms of the key values, beliefs, practices and concepts which together specify the field of action of nursing or midwifery. Would the debate look for generic issues or seek cross-fertilisation? What would be the criteria by which contributions are accepted? Or, are the contributions to be drawn upon in an ad hoc way?

One strategy to encourage cross fertilisation and the production of generic understandings is to introduce some notion of shared learning:

> *Just as midwives do not practice in isolation the course will not be delivered in isolation. The student midwives will participate in some shared modules of learning with other students in the university – mainly but not solely – nursing students.*

The pressure for economies of scale have led many institutions to place medical students, nurses, midwives and biology students and so on in the same lecture theatre. At one level this could be called shared learning. However, there is no necessary relationship between a mixed audience of students listening to the same talk and the process of 'shared learning'. The aim is often expressed:

> *These disciplines are based on the synthesis of relevant knowledge drawn from biological and behavioural sciences, humanities, medical art and science and from the knowledge generated by the nursing/midwifery profession. Clinical practice is the application of the knowledge; it is therefore imperative that the course demonstrates the integration of nursing/midwifery theory and nursing/midwifery practice.*

Typically, the documentation is clear that there are processes of synthesis and of application. This is often further specified in terms of critical, research-based approaches to care. Undergraduates are asked to bring localised understanding to the level of generalisable insight. For this to happen, planned opportunities for the integration of practical knowledge with other forms are essential (See Chapter 7: Section 7.3) Only a limited number of curricula make provision for this, leaving undergraduates to critically evaluate a wide range of theoretical perspectives privately in their heads or amongst informal peer groups. Development of understanding in these circumstances depends almost entirely on the students' personal development as thinkers and mature people.

The question remains, how is a course to be structured in operational detail?

4.3 Marrying educational and management requirements for curricula

- ***Responding to official directives.***

The requirements of professional bodies (i.e. ENB, and UKCC) and of European Union directives are comprehensive. The specification in curriculum documents of operational detail to meet those requirements can be seen as a discourse between educators and bureaucrats. The key 'bureaucratic' requirements for pre-registration undergraduate programmes can be briefly outlined as follows:

- For pre-registration nursing curricula (Parts 12-15 of the UKCC Register), students must meet the competencies laid down in the Statutory Instrument 1989 No. 1456 (Rule 18a). Students are required to gain experience in a wide range of hospital and community health care settings. Programmes consist of common foundation and branch programmes in adult, mental health, children's or learning difficulties nursing. In most circumstances, the ENB do not approve a course offering only one branch of nursing (ENB 1993 p 3.77 in ENB 1993-1995). Common foundation and branch programmes are required to be 18 months long full time (or equivalent), and each comprising 2,300 curricula hours. The total length of the programmes should not be less than three years full time or equivalent, comprising of 45 programmes weeks of learning units. Of the minimum 4,600 curricula hours, it is expected by the Board that half of this time is spent in learning practice settings (ENB 1993:3.78 in ENB 1993-1995).

- Midwifery courses are required to demonstrate midwifery content and application throughout the whole course which relates both to theoretical and practical experience. Pre-registration course in midwifery must not be less than three years duration (156 weeks) including annual leave (ENB 1994 p 3.64 in ENB 1993-1995). The minimum total practice related content should be half of the programme (ENB 1994: 3.64 in ENB 1993-1995) and midwives must meet the competencies laid down in the Statutory Instrument 1986 No. 786 The Nurses, Midwives and Health Visitors (Midwives Amendment) Rules Approval Order (Rule 33). In clinical practice the midwifery students have to achieve the requirement laid down in Article 27 (European Community Midwives Directive 80/155/EEC and its amendment 89/594/EEC) which specify quantitative experiences in ante natal, intrapartum and postpartum care and.

These highly specific requirements can be read as constraints which restrict or distort educational processes to fit bureaucratic requirements. Or, they can be interpreted as necessary safeguards to ensure standards across very diverse institutions and contexts. These minima are interpreted individually at each institution (See Appendix 1).

- ***Responding to institutional constraints.***

In addition to meeting the requirements of the professional bodies, curricula are designed to fit within institutional structures. This can be a formidable task in itself, more so when institutional structures are also changing (eg: to semesters and modular programmes) or when staff are responding to changes (eg: in faculty structures). Clinical learning requirements must be negotiated with clinical partners and other student populations to ensure that clinical areas and staff are not inundated with students (See Chapter 6). And clinical learning must dovetail with the theoretical components of the course, which may mean accommodating the timetables of other groups of students where shared learning occurs.

The challenge becomes how to create and timetable processes and structures which fit well within the institution at the same time as creating a curriculum which enables students to integrate their learning into an emergent professional identity.

4.3.1 Operational integration of theory and practice : the 'bureaucratic' approach

The 'bureaucratic' solution to the issue of theory-practice integration is to reduce the problem to one of defining when, where and how often theory and practice occur during the lifetime of a course.

One operational strategy for achieving theory-practice integration is the one described below:

> *Integrated clinical modules are successfully completed when students have achieved learning outcomes. Some of these are expressed as knowledge base acquisition.*

> *However as the programme progresses, an increasing number are written in terms of application of knowledge, the acquisition of skills and internalisation of concepts which are reflected in clinical performance. The clinical placement is therefore, an integrated component of the module.*

Other strategies concentrate on the graduation of theory and practice from a weighting in favour of theory in the first eighteen months to a weighting in favour of practice in the final part of the course. For example, one three year nursing degree allocates 62% theory and 38% practice in the common foundation programme, and reverses this situation to 38% theory and 62% practice in the branch programme. In another three year programme, the weighting is even more pronounced with 70% theory and 30% practice in the common foundation programme, and 28% theory and 72% practice in the branch programme. Such strategies do not necessarily mean that reflection appropriate to the educational processes leading to real integration will actually occur. The successful integration of theory and practice into a coherent framework for professional development and judgement involves a lot more than scheduling and co-ordinating blocks of theory and practice.

An alternative to the purely operational strategy is the 'operational-cum-teaching' solution. This sets out to solve the same problems by structuring teaching and learning in ways intended to lead to the integration of knowledge from different fields and a wide variety of contributory disciplines. The data makes it clear, however, that there is a danger in the development of courses which 'for all practical purposes' are integrated. 'For all practical purposes' students sit in the same hall and hence 'share learning', or listen to lectures from different disciplines, but little integration takes place:

> *It was a case of, "This is what I've got(...) it was pick and mix. The Head (...) came and said, "I've got 30 modules which are roughly relevant for you, I think. Have a look and see what you want." And we picked the ones out that we thought were ...(pause) but you never know from a module outline what the content is.*

4.3.2 The integration of different types of knowledge: the educational approach

A different approach to the 'problem' of theory/practice integration is one which looks at how best to bring together in an appropriate relationship the range of forms of knowledge which inform nursing and midwifery theory and practice. The following descriptions identify significant differences in the way the 'problem' has been tackled.

At one institution, integration has been achieved through thematic teaching, the first eighteen months being taught through themes which provide the foundations of knowledge in the biopsychosocial aspects of nursing and midwifery and some professional issues common to both professions. The teaching is done by subject specialists and by nursing and midwifery lecturers.

A second programme aims to achieve integration through the progressive development of conceptual difficulty. Students are offered increasingly complex theoretical material, and encouraged to move from analysis to synthesis. The course has been very carefully

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organised for coherence, drawing on the four disciplines of life science, psychology, social science and information technology.

An institution offering both a 4 year nursing and midwifery course sought integration by having all units within the course delivered by qualified nursing and midwifery lecturers within the Faculty. There was no cross-faculty teaching from specialists who were not also nursing or midwifery specialists. Within the curriculum there was an expressed aim to integrate knowledge through the process of enquiry and reflection. This was facilitated by the use of learning contracts and professional learning objectives. Members of staff were actively involved in helping students synthesise their experiences.

Another four year degree was organised on a modular basis. The modules had broad themes of health education/promotion, behavioural science, biomedical science, epidemiology, research and its application. Some of the modules were shared with students studying biomedicine, social policy, and behavioural science.

The curriculum planning problems for nursing and midwifery educators are how to provide a framework for critical reflection about theory and practice, and how to ensure discussion about the range of perspectives represented in contributory disciplines. As the examples demonstrate, if a coherent degree is to be created, then there is an imperative to provide *educational* structures that attend to more than the balance between theory and practice at given points in the course. They must bring people and disciplines together within nursing and midwifery frameworks.

4.4 Resources for collaborative curriculum design and development

Evidence suggests that programmes which encourage thinking are most often produced in circumstances which themselves enable reflection and dialogue. Where circumstances lead to intense pressure, emphasis may be on an end-product (that is, the finished documents) rather than the discussions which develop educational process.

> *I think there was a lot of complacency around (...) when we came to do this new revision of the course. I spent over a year having discussions about (...) the model on which we were going to base the course (...) somebody said to me in that phase, "This is quite different to what we've done before. At the last validation we used the stapling together method (...) we just wrote little bits of the course that we wanted to do and it was stapled together and sent to the ENB."*

Human resources and time are critical if curriculum planning is to be a collaborative discourse. At one institution staff were able to build on existing experience of degree level education when designing a new programme, in a time frame which allowed them to explore differences in understanding:

> *I was involved as a, as a practitioner in the validation of the mental health branch of the course, and basically it looks as though they took the old curriculum and threw it on its head and started again. They didn't try and get the four years that were there and squeeze them into three years, which couldn't be done, they, they started*

> *again and, and looked at, you know, what is relevant and what isn't. And I was very impressed with the curriculum and particularly the mental health branch, and I remember thinking at the time, "I wish I'd done this, it sounds, this looks great."*

Curriculum development here is based on dialogue, reflection, collaboration and experience.

Where curricula were prepared at speed, heavy commitment was demanded from small, dedicated groups:

> *I think the big disadvantage was that we didn't have time, as so often happens when you're writing a new curriculum.*
>
> *...certainly the course structure, I had to do it in four days. That's what I had to do. And we were starting from no experience of modularisation, the university weren't modularised at that time, and they weren't working in semesters or anything, so we were starting from nothing.*

Dedication cannot always make up for lack of time and available personnel, however. At one institution, a plan to commence with a first undergraduate intake following five months preparation for validation and three months thereafter, soon collapsed. The time-scale proved insufficient to develop an educationally sound programme:

> *...the reason it took so long was we started off with this remit to develop this course with really having very few new units in it, but to have shared units with the Dip HE and other units across the university, where apparently there is this grand plan the students can dip in and out of units, you know, in other schools like management and so on. So we tried to do that and we had such a short time scale that when it came to the internal validation, apart from the problem that we lost the document of the disc (...) it was very muddled, it was not clear err, what they would be sharing with the DipHE, and you know, the educational question was you know, if these students are doing a degree how can you mix them with the Dip HE students.*

4.4.1 Resources and clinical staff participation

Ensuring the participation of key clinical representatives in the curriculum design process posed difficulties where clinicians were highly pressured by practice commitments. Pressures on clinical staff are reported to be high (See Chapters 8 & 12). A director of patient service commented on the staffing implications of such activity:

> *But you can't really send a manager plus a G grade because you just can't afford it, because it's tremendously time consuming. And we're, although I'm committed to helping the curriculum to be produced to produce nurses and midwives we want, that commitment has also got to be a commitment to keep them here to care for the patients as well. And we are so strapped now within the NHS that you've got to try and get that fine balance between the two.*

The financial implications and the often unpredictable demands of client care frequently mitigate against continuity for curricula design:

> *...we had a service member from each of the areas, two midwifery representatives and a colleague from the paediatric areas, mental health. (...) We didn't have the same person the whole way through (...) it was actually difficult getting somebody from the adult side.*

> *...like a lot of other development processes you start off with a lot of committed people and the commitment wanes and you end up with a few workers doing it.*

This is a familiar scenario for educationalists involved in curriculum design. Nevertheless, most strive to ensure continuity of representation of clinical staff to develop shared understanding, and to aid vision and ownership of the undergraduate programmes beyond curriculum design to curriculum implementation.

4.4.2 Resources and education staff participation

The design and development of a successful undergraduate programme also requires collaborative relationships between educational colleagues.

The politics of some institutions favour insularity and competition between faculties; staff in these places crave assistance and consultation. In other institutions, supportive human resources have transformed the curriculum development process into a productive and enjoyable learning experiences for inexperienced staff. In many, however, a particular effort has been necessary to find mutually acceptable times and spaces for curriculum planners from professional and academic boundaries to meet and generate cross-professional understanding:

> *...the academic co-ordinator (...) has never failed to come here for any meeting (...) On our planning team we had a Professor of Obstetrics, who also had no problem coming (...) to meetings if commitments allowed. (...) (the Professor) has midwifery at heart, speaks midwifery as an obstetrician and believes that obstetricians and midwives should work as equal partners, and we welcomed that.*

> *...we progressed along that path but in retrospect it was very, very vague and again it...it all took so much time...because everybody was busy and our Professor was away a lot and at first he was always involved with the meetings and it was when the meetings could be organised and of course the university staff were busy, and it was getting to the right people within the university. So really what happened by the time it came to first validation (it) was more or less without much consultation with the university. We'd put together a curriculum which was not really the ideal way to do it at all but (...) we had to be doing something.*

During periods of change, familiar reference points become dislocated, underpinning structures may crumble and no longer unify the many aspects of everyday experience. At worst this can manifest itself in gross misunderstandings about procedures which then have to be 'sorted' at both an economic and educational cost:

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> *...because of being out of synch with validation cycles and other cycles when the bid went in for the money (...) we put in for the wrong kind of bid, because the people who were putting in our bids bided for a sandwich programme, 'cos they hadn't really asked us what we wanted. So we weren't putting in our own bids, we were relying on other people to do it, who knew the system. So in effect it was turned down I think because the institution agreed it was their cock up and said, "Oh well, we'll have to underwrite it for this year and see about Funding Council money next year."*

Any lack of expertise or confidence must be compensated by drawing on internal support networks. Some institutions appear not to have the necessary infrastructure, have inadvertently excluded nursing and midwifery planners from access to them. Some nursing and midwifery educators have lacked the confidence or opportunity to seek entry to them. The isolation of nursing and midwifery staff at the planning stage of programme development increases the likelihood of increased pressure on both them and the students when the programme is operationalised.

Collaboration succeeds best where relationships are equitable. Some nurse/midwife lecturers and practitioners report feeling like junior partners in discussions with higher education colleagues from other disciplines. They find it difficult to shake off the legacy of relationships which have in the past been experienced as imperialist or patriarchal:

> *...making sure that you have actually someone who has that kind of expertise to advise you in negotiations with higher education seems to be quite crucial to getting the best deal. I think really perhaps we very naively went into some of our negotiations (...) rather than actually negotiating from a point of knowledge and strength.*

> *...not with other subjects, but with nursing there's been more what I call a form of malignant patriarchy. Not so much by the faculty of medicine, but by other departments who take a particular interest in wanting to be involved in what they call the academic rigour of our degrees. They want to be fully involved, and yet if I say to them, "How many nurses were involved in your curriculum?" or, "How many of my team are involved in setting your examinations?" there's a sudden blank look.*

Where nursing and midwifery curriculum planners find themselves trapped within rigid, institutional and parent-child relationships, there is a strong possibility for nursing and midwifery to be relegated as an "add on" to powerful existing professional domains:

> *They deal with it, we have no input into it, we have no control over it.*

This is bound to constrain change in ways that are likely to affect the development of professional competencies such as evaluation and judgement.

Nursing and midwifery curriculum design occurs in a dynamic context and those involved require time and resources to reduce the pressures of post hoc curriculum development which can, and often does, lead to considerable stress. Collaborative planning helps to overcome the problems created by the fact that education and clinical staff often have different kinds of theory.

4.5 The 'politics' of curriculum planning

The process of curriculum planning can be seen as a more or less successful struggle to harmonise management and education agendas. In this sense it is political in nature, taking the form of a 'micro politics' played within and between departments and individuals and groups. This is not a party politics but a politics of HE in the widest context. For those unfamiliar with this politics, attempts to put a professional philosophy into operation against the background of bureaucratic and political constraints can be extremely draining. A sustained effort may be required to effect a small change.

For all higher education planners curriculum design is an enacted discourse in which they try to make sense of competing demands. For the planners of nursing and midwifery degree programmes the associated problems are particularly acute.

On the one hand, they find themselves at the centre of an unresolved higher education discourse about course management and institutional bureaucracy. On the other, they are located in a competing set of discourses about the place of different forms of knowledge in nursing and midwifery education, and the role of critical reflection in the development of both theory and practice. This uncomfortable position leaves staff pursuing an educational ideal through commitment to certain professional values within the context of a bureaucratic system which imposes an administrative definition of a 'problem free' course that runs like clockwork from the outset.

4.6 Summary

The planning of nursing and midwifery curricula is a complex activity which has to answer both bureaucratic and educational questions. The high professional aspirations of nurse and midwife educators inspire them to seek to produce a curriculum for a degree that is as close as possible to the ideal degree which universities purport to offer but which is difficult to achieve in actuality without the necessary underpinning structures, resources and cultures to ensure delivery. The requirements of professional bodies and HE institutions mean that the realisation of the ideal is made more difficult.

Institutional factional and political interests are perhaps a greater problem for those trying to create a programme unified around the concept of 'professionality' in nursing or midwifery than they are for those planning a more traditionally academic degree because integration threatens these interests. The question remains, what makes one degree more likely to succeed than another?

At least in terms of the planning stage, it seems that some of the factors which portend success include the following:

- realistic time scale for development which enables harmonisation and integration of the curriculum;
- clearly specified resources and mechanisms for bringing together, and ensuring continuity between, those who teach the disciplines and facilitate learning in clinical settings, which contribute to the nursing or midwifery curriculum;
- in the case of clinical staff, the resource implications of regular attendance at curriculum planning meetings must be acknowledged and met, to ensure that such an essential contribution is not marginalised by the often unpredictable demands of clinical practice;
- well developed HE infrastructures for supporting curriculum planning according to educational principles;
- infrastructures must be able to meet the particular needs of those new to curriculum planning within the institution, and/or at unfamiliar academic levels;
- an explicit recognition of the relationship between the institutional culture and the culture of the nursing/midwifery department;
- clearly identified management and educational agendas, with a full recognition of those places where there are conflicts of interest;
- mechanisms for establishing the educational (as opposed to the bureaucratic) agenda of curriculum planning meetings;
- teaching and learning structures which favour the integration of contributory disciplines, without compromising a professional midwifery or nursing focus:
- the development of a clear rationale and strategies for the distribution and integration of theory and practice elements throughout a course;
- a detailed evaluation structure for orderly, on-going curriculum development that recognises the fact that the 'ideal' degree is an aspiration.

But generally, because no amount of staff time expended in curriculum planning at the outset can ensure that the curriculum produced is perfect, thought must be given to creating educational structures for on-going development.

CHAPTER FIVE

Implementing the curriculum in action: recruitment, organisation and resources for learning

Introduction

Designing a curriculum is not the same as delivering it. The material or resource frameworks which construct the delivery stage are critical to its implementation as a faithful, rather than a distorted, representation of the design.

The curriculum *as designed* guides the curriculum *as actually experienced* within the 'learning environment'. The curriculum is both a biographical and an historical construct that describes the passage of an individual (whether student or staff) through the learning environment.

The function of management can be to impose bureaucratic demands upon the learning environment. Alternatively, it can be to service the needs of a learning environment. Or, it can be the means through which compromises are formed that, although falling short of the ideal, do not subvert educational and professional values. If management seek to distinguish between 'policy' and 'operational' levels, while keeping a foot in both arenas, however, there may be confusion in decision making and action.

5.1 Student recruitment

The first factor affecting the extent to which the aspirations in the designed curriculum are realised is the range and quality of the students recruited to take a course. Recruitment policies directly affect the quality of the learning environment, and thus the nature of the learning experience, bystructuring the profile of a student cohort. What students bring in terms of life experience, cultural and social background, ethnicity and gender has a considerable affect on howthe total cohort reflects on their learning. What the candidate looks for in the degree and what the university looks for in the student, therefore, can reveal the nature of the educational journey to be undertaken and the kind of resource and management structure required to service it.

All institutions report healthy numbers of applications from suitable candidates, although midwifery, adult nursing and children's nursing are frequently oversubscribed compared to the more modest interest shown in mental health nursing and learning disabilities nursing.

As numbers of undergraduate courses in nursing and midwifery grow, greater publicity surrounding these alternatives to diploma level routes appears to be having positive effects on careers information. Similarly, the message of pre-registration midwifery courses which do not require initial registration as a nurse is spreading. However, from some lecturers' and students' accounts, there appears to be room for further publicity:

> *Careers teachers still seem to have certain difficulties about nursing degrees in general. They know about Project 2000 now and everybody seems to be directed into Project 2000. So I think initially there were problems with that.*
>
> *(I) hadn't really heard that much about degree nursing...I hadn't really researched it very well at all, umm and then looked into the PCAS handbook (...) and realised there were degree courses.*
>
> *I didn't apply for the degree, just the ordinary conventional course. I didn't know there was a degree. And then I was accepted and they suggested that I apply for the degree course because it was coming up.*

Student admissions are managed by one or more members of staff carrying a recruitment portfolio, often assisted by colleagues. Prospective undergraduate students apply through the Universities and Colleges Admissions Service (UCAS). The UCAS system is relatively new[1]; lecturers are required to either familiarise themselves with recent changes, or to get to grips with a totally new system if previous experience has been with pre-registration candidates for certificated or diploma level courses through the Nurses' and Midwives' Central Clearing House:

> *...I mean that's the difficulty, because it's only my second year of recruitment time (...) it's a bit like playing Russian Roulette. You don't know how many to take, and what the 'A' level results are going to do, and I was really perspiring madly on the 19th of August last year because having offered that many places I wasn't sure whether I'd done it right or not. In fact I was short of one person, so I had a reserve list of people.*
>
> *There were problems in that we were going through PCAS and UCCA and none of us knew the system because for nursing it had a Clearing House and its own system. So I think ignorance on our part of the whole system and how it worked, and that you needed to start a whole year in advance were problems. We didn't know about how the rest of the institution organised things, so when they said we have an open day, we didn't know what was involved in the open day.*

Prospective students are required to demonstrate academic ability and personal qualities. Standard academic entry requires success at GCSE/GCE 'O' and 'A' level, or equivalent qualifications for example Scottish Certificates of Education, Business and Technician Education Council (BTEC) Certificates or Diplomas, General National Vocational Qualifications (GNVQs), European or International Baccalaureates or Access courses. Mature students with non-standard entry may be considered on the basis of individual merit. Specifications of entry requirements and grades in institutional prospectuses vary for individual courses; some, but not all, indicate grade requirements and typical offers.

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[1] UCAS replaced the former admission bodies of universities (UCCA) and polytechnics and colleges (PCAS) for entry in the academic year 1994/5, following the dissolution of the 'binary line' of university and polytechnic status.

Examples from institutional prospectuses include 'A' levels grades of BCC; CCC; CC and three GCSEs at grade C or above; two passes at 'A' level (no grades specified); five GCSE subjects, two of which must be at 'A' level.

Actual qualifications and grades obtained by candidates accepted onto the courses may differ from those specified, for example where entrance requirements are lowered during clearing to ensure full recruitment. Academic qualifications of students comprising the first cohort of a course are often reported to be anomalous due to the often limited time to advertise the course following validation:

> *...we had a very low 'A' level point intake when we recruited (...) we were recruiting really after an approval in the summer and we had very little time to recruit, we had to recruit through clearing so we're probably talking about 8 or 9 ('A' level) points at intake level...*

> *So for last year, I think recruitment was not terribly good. So what happened was in clearing we got a lot of students. Now one of the problems in getting students in clearing is, although by and large academically they weren't too bad, although we've got a policy that says 12 points, we did actually take people with two D's or a C and two E's and whatever.*

Entry in HE, long dominated by school leavers with 'A' levels, has been broadened in recent years to accept more mature people, with alternative qualifications and from varied backgrounds. However the extent to which mature or non standard entrants are encouraged to apply for specific undergraduate courses at individual institutions varies. Issues of gender, age and ethnicity are all important issues for recruitment into nursing, where until relatively recently white, female school leavers have formed the mainstay of entrants. Similarly, trends in midwifery have reflected those of nursing, albeit with an older age profile on entry as the post-registration – now termed 'pre-registration (shortened)' – route predominated (See Chapter 2).

Equal opportunities policy is recognised as directly affecting client care:

> *...if we are going to get education to be only at degree level into midwifery, which means two 'A' levels, what is our recruitment pool going to be, where does equal opportunities come in? I think we need to get not only schools education sorted out, but also the Access programmes. I am very hot on Access programmes because I think they are really good. That needs to be sorted out so we can actually attract non traditional people, otherwise we are going to have white, middle class midwives. (...) In some parts of the country you can see alienation from the profession as we will be seen as just another white, middle class profession like the doctors, and midwifery itself is with woman, it is not above women, or pushing women, it's actually with them, so I think that midwives should actually reflect the population that they serve. Now obviously you can't go to a population and say, "Oh we have a very big Greek Cypriot area here, we only want a Greek Cypriot midwife." I am not going that far. But having a population that is very mixed, not only ethnic, but also its social makeup allows women to have midwives who can actually relate to them,..*

Successful strategies to recruit mature students have been reported. These include increasing the awareness of alternative entry requirements to 'A' levels and positive attempts to attract mature, local candidates. Some undergraduate programmes have established links with Access to Nursing Courses at local colleges, and several places in each cohort are reserved for successful students:

> *For example, we, I work very closely with a Further Education College and I offer two guaranteed places for the Access to Higher Education in Nursing. So of the 26 (...) two of those at least are guaranteed places. And sometimes, although we say we guarantee two, and we would look at other Access students and they would compete with the pool of people who are competing for places with non standard entrants. And it might well be that two more from the same course get places. We take a number of mature students who might not have got an Access course, last year our intake, more than 50% were mature students, over 23 years we use.*

The experience of successful Access students as undergraduates fosters understanding of, and confidence in, Access programmes as a sound preparation for the demands of degree courses.

Recruitment of male students and students from ethnic backgrounds (and on some courses mature students) is reported to be low. One suggestion from staff involved in recruitment is that few students in these groups apply:

> *We have very, very few people from ethnic minorities here. In fact we had only one ethnic minority applicant last year.*
>
> *We try very hard to umm, sympathetically look at male applicants, at people from ethnic minorities, and from mature people but you can only work with what you get...*
>
> *But I still can't recruit enough. No, I'd love to. I mean I definitely would, if, if anything I'd be more inclined to take male nurses, if I saw a candidate that's a male nurse I'd think more (...) I'd be more likely to take him if I could, but they just don't apply.*
>
> *What I still haven't got very much of is people from ethnic minorities and erm, that's difficult.*

But the response is different where a positive effort is made:

> *.....really it's multicultural (...) I've taken from absolutely everywhere really .. the broader the better as far as I'm concerned*
>
> *... if we are going to get education to be at only degree level into midwifery, which means two 'A' levels, what is our recruitment pool going to be. Where does equal opportunities come in? I think we need to get not only schools education sorted out but also the Access programmes (...) so we can actually attract non-traditional people, otherwise we are going to have white, middle-class midwives (...) midwifery*

> *is with women, not above women or pushing women, it's actually with theem, so I think midwives should actually reflect the population ...*

Staff speculate that the enduring image of nursing and midwifery workforces as predominantly female acts to deter prospective male students. The perception of nursing and midwifery as low status in comparison to well established professional groups is suggested as a detrimental factor in attracting students from ethnic backgrounds:

> *...I think the other reason why the other male nurse that I'd recruited didn't come was because he was of an Indian, Indian background and they (his family) didn't really feel it was the thing to do, to nurse.*
>
> *(Students from ethnic minority groups) just don't apply, nursing is not a high priority. Medicine is, but nursing is not seen as a desirable state.*

Recruitment of students from ethnic minority groups into nursing, midwifery and health visiting is an issue of national concern. The commissioning of research in this area by the ENB is welcomed (ENB 1995c).

Whether prospective undergraduate students are financially able to support themselves is another key recruitment issue. In the short term, opting for an undergraduate course in nursing or midwifery as opposed to the diploma level route is financially punitive (see Chapter 10). Undergraduate programmes attract smaller, diminishing levels of means-tested Local Education Authority maintenance for students in comparison to diploma level courses which secure higher levels of non means-tested NHS bursaries. The undergraduate route may become a less viable option for prospective students of limited financial means:

> *The HEFC funded students are severely disadvantaged, and I know there is a lot in the press at the moment about the low level of bursary, but the relative poverty of the HEFC funded student...umm that could be a dramatic problem for us...in terms of our students get a reducing grant, they don't qualify for expenses for travelling they have to fund their own accommodation rather than perhaps get it subsidised, and I think the effect is that it has a... it has many unattractive features to it.*
>
> *I interviewed a person not long ago who had 'A' levels for the Dip HE, and I did ask the person, "Why are you not considering the degree?" And the person said, "I won't get the grant. I won't live on the grant, I can't."*

This may be another equal opportunities issue for further study.

The majority of people who opt for nursing or midwifery undergraduate degrees are particularly well motivated. They make a positive choice to study midwifery or nursing, and many (particularly mature students) have been intent on their area of study for a considerable time.

Choosing an undergraduate degree in nursing or midwifery as opposed to a diploma level (or formerly certificated) course was predominantly an active decision made by students who felt that degree status represented future trends in the nursing and midwifery professions, that a degree would stretch them intellectually, and that being a graduate per se was advantageous for career flexibility.

In general, then, the nursing or midwifery undergraduate student is someone who has made a positive, informed choice regarding their course of study. Their sense of enthusiasm and commitment to nursing or midwifery practice means that programmes have an excellent opportunity to capitalise on this enthusiasm to build an exciting learning environment. Where recruitment policy is also alive to the need to encourage candidates from a wider social and ethnic background and to even up the balance between the sexes, the 'outset' conditions for a *lived* curriculum which meets the aspirations of the *designed* curriculum appear to be optimal.

5.2 Staffing: quantitative and qualitative dimensions

Staffing has to be considered from two perspectives. The first is in terms of quantity. There have to be sufficient numbers of 'hands' available, with the appropriate skills to do the range of jobs required, otherwise stress and burnout are likely consequences. The second is a qualitative dimension. By this is meant the symbolic arenas for debate, meaning making and the construction of understandings, theories, models and paradigms all, of which contribute to the lived curriculum produced in the learning environment. Staff have a vital role to play in this. Both as individuals and as groups; the ways in which staff work with students to produce this learning environment is critical to the quality of a degree.

5.2.1 The quantitative dimension

Complements of staff contributing to undergraduate courses vary greatly in terms of size, roles, academic and professional expertise and stability. Staffing is strongly influenced by institutional histories and subsequent amalgamations, mergers and new directions for departments and faculties of nursing and midwifery (see Chapter 3). ENB requirements for staff student ratios (SSRs) are currently under review following ENB commissioned research which confirmed that SSR calculations do not constitute reliable indicators of quality in educational provision (Proctor, Murray, Reed & Sedgewick 1994). This is not to say, of course, that numbers have nothing to do with quality. It would still seem sensible to suppose that insufficient numbers of staff, no matter how well motivated or how professional, would inevitably compromise educational values and hence quality. Consultation with the professions to seek more sensitive and appropriate quality indicators (ENB 1995d) is thus welcomed, particularly in light of research findings by Proctor et al.

The majority of staff delivering the nursing and midwifery degrees are lecturers, although a small number hold joint appointments between HE and clinical areas, or lecturer practitioner posts. Their terms and conditions of employment vary between institutions, and in some instances within institutions[2].

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[2] Staff at some institutions remain on NHS contracts following integration into HE (see Chapter 3).

CHAPTER FIVE

Implementing the curriculum in action: recruitment, organisation and resources for learning

The activities of nursing and midwifery lecturers include teaching and academic supervision, liaison with clinical placement areas, research, student support, clinical practice and administration. Roles may focus on a particular course such as an undergraduate programme, or they may be spread over a range of courses; the trend is increasingly towards the latter as pre-registration undergraduate courses operate alongside a range of pre- and post- registration courses in nursing and midwifery. Ensuring that the staffing base can meet these varied demands is essential. Constraints on resourcing seem to be pervasive, however.

Institutional mergers and amalgamations have had a significant impact on staffing levels and the nature of terms and conditions of employment. One lecturer awaiting the outcomes of local educational mergers described the local situation thus:

> *...we were three teachers short and had been for months, and everyone obviously had an increased workload, and because we were in on the contract situation, staff wouldn't be taken on.*

Re-organisation can also affect the stability and continuity of staffing complements, which in turn may affect course quality. Continuity in the form of those involved in the design of the degree taking the vision forward into operation is desirable. Changes at institutional and departmental level mean that it is not always possible. Taking forward a 'ghost curriculum' is a challenging prospect:

> *So when the course was first written we didn't have anybody in post, so it was really written as a ghost curriculum.*

Role strain can occur where it has not been possible to ensure that the staffing base covers the extra demands posed by practice based degrees with extended academic terms. Some staff have 'compensated' for this by marginalising activities which create less urgent day to day demands, such as professional development research:

> *I think without umm a, a clearly thought out strategy to (...) to protect staff personal development time, to, to protect the research focus and interest, to legitimately feel able to take leave to your entitlement and study time without feeling you're neglecting your students or you're neglecting your colleagues, it really needs to be carefully ironed out.*

> *So I don't think I anticipated the pressure (...) I knew I would have to do the research and in fact that was an attraction, but I don't think I realised how much other work there would be to do that means that (...) there is just no time. (...) I think my ideal would be to do a full time Ph.D. or a full time research project, not trying to marry the two.*

> *The problem really is that you can negotiate yes, you'll do something, but it's what goes out the other end, and as an example of that we had, the person who used to teach the surgical module left and there was nobody to teach the surgical module. So because it ran in a quiet term I was asked if I would take it on, and at that point, that was just when I wanted to register for my MA, and I said, "Well yes, but you*

> *do realise that I can't do that and research at the same time." Well at the time it was, "Yes that's fine don't worry about it," so I was actually running two full time clinical modules in one term (…) and when it came to it, I was still penalised for not having registered for my masters.(…) I'm on a short term contract and I have been told in no uncertain terms that my contract will not be renewed unless I've got my MA.*

The majority of nursing and midwifery degrees operate over extended academic terms; for all three years degrees 45 week academic years are the norm, and many four year degrees operate for 40 weeks per year or over, with the longest being 45 weeks (See Appendix 1). In its consideration of the feasibility of three year undergraduate degrees, the PCFC Nurse Education Advisory Group highlighted the need for adequate resourcing, commensurate with the specific requirements of 45 week programmes:

> *The group emphasises that the success of a combined three year course of education and training leading to a degree in nursing (sic) and a professional qualification will depend on adequate staffing levels. Resources will need to be made available to cover staffing costs throughout an extended year both within institutions and for teaching and supervision during practice based learning."*
> (PCFC 1989: 5)

A 45 week year will require a quite different pattern of resourcing to that of a 30 week year if quality is not to suffer and compromises become unacceptable. Ensuring that the additional demands created by professional degree are recognised is a message that many have found the constant need to reinforce in order to secure adequate resources:

> *And I don't think the university has ever planned for that in the sense that universities always work to a 1:20 and they certainly have difficulty with the contact hours in the placement. (…) Our university is very vocationally oriented, but I still don't think people understand that it's a 45 week year…*

Extended academic years leave little space for staff to reflect on each years progress, review, update and develop course teaching materials (particularly on new programmes), take vacations and pursue scholarly activity before student admissions and clearing signal the approach of the next academic year. Where there is a lack of space or down time, a continuous cycle of draining activity is experienced:

> *…there's an accumulated tiredness certainly in my experience I'm absolutely exhausted, I still haven't marked this year's dissertations, and I've got students coming for next years and competing for supervision…*

> *Now as you can imagine the academic year starts in late September and runs through until late August, with about a month intervening without cohorts. It's a problem for the students in that they, of course they want to get some employment and some holiday and some refreshment time and that's quite a short time. For the staff, we immediately go straight into full-time recruitment mode through clearing and results which happen at that time. So it's quite difficult to take annual leave at the time when the students are away, at that time in the summer.*

> *One can see that next year when we have our second intake and when we are up to steady state, we are probably going to have students here throughout the year and only one breathing space of four weeks, and that breathing space is going to occur when UCAS activity is at its maximum in summer. So its really, I mean speaking personally it is difficult to get your seven weeks annual leave a year in, very difficult.*

Revalidation of one four year programme into a modular structure has significantly lengthened the academic year (from 38 weeks to 44). A lecturer from the programme describes current pressures on staff thus:

> *Huge, absolutely huge because the introduction of our new modular programme means that our students, I'm talking about the degree programme, students are away for only four weeks in the summer – really they are hear all year apart from some point or other. So the pressure on staff has been huge.*

Damage to the quality of teaching is inevitable if resources are inadequate. Institutions which respond to staffing crises by drawing more heavily from existing resources increase the burden of pressure on existing staff, and student learning is put at risk.

5.2.2 The qualitative dimension

Staff involved in the delivery of an undergraduate course require relevant expertise and experience to fulfil role demands. The overwhelming majority of nursing and midwifery lecturers contributing to undergraduate programmes are graduates, studying for or holding postgraduate degrees at masters or doctoral level. But is there a distinction to be made between qualification and credibility, qualification and professional development? It is quite possible to advance the qualifications of staff without ever constructing a community of debate which is the precondition for the construction of mutually supportive learning environments appropriate to both students and staff, whether for teaching or for research.

In terms of academic credentials though, there is considerable variation between institutions and individuals. The ENB (1994: 2.9 in ENB 1993-1995) state that *"Teachers/lecturers should hold qualifications appropriate for their contributions to the courses being offered."* The professional development needs of individual staff have varied significantly during the TYDE project. There has been considerable professional achievement as staff simultaneously undertake academic study and develop and operate undergraduate programmes. A small number of non-graduate lecturers teach on undergraduate programmes whilst concurrently studying for first degrees or masters level qualifications. For example, one lecturer, a recent graduate without honours teaching on an honours level course:

> *...so now obviously I'll look towards developing that into some form of higher degree myself. I don't feel inadequate at the moment because (we're) only like at...year one of any degree course (which) is more at certificate level isn't it. But obviously once I've got this course sorted out as well as I possibly can, then I need to*

> *be looking to something else which this institution is keen for me to do, but they are not pushing me because they know I've a lot on at the moment.*

As the lecturer above comments, studying for professional development while teaching can be a considerable burden on top of other already demanding roles. Reviewing the professional development needs of staff before courses are established is the ideal to ensure the creation of appropriate academic cultures; due to the of course design and implementation, and factors of institutional change. This has not been possible for every undergraduate programme.

Professional development may also take more basic forms in order to ensure that staff who are new to the university sector are confident and skilled with methods and approaches for teaching and learning at undergraduate level. Changes in culture can not happen overnight, and resources of time are required for dialogue and networking. Exposure to new, challenging academic cultures through institutional mergers or professional development may act as key turning points for staff:

> *I actually developed a hatred for the culture that I was coming from, a loathsome hate for the hierarchical, autocratic rubbish that I had grown up with. And I just loved being, I still love being, amongst those guys. I love the dialogue, the discussion, the challenges.*

Pressures may be high, and often fluctuate according to changing circumstances, as the following account shows:

> *I think if you asked every single teacher they would say they had never worked so hard in their lives. They would probably say they had never enjoyed working as much as they do now, because it has been great. Umm...but it's been, I would say the pressure has been extremely high. Sometimes it isn't as high as it is now, so you are asking at the point of highest pressure, because we are coming to the end of the foundation studies programme, it's that time of year when exams start to, we've got students coming up for the final projects, the final examination. Umm, so there has been a great deal, there has been the new development with the new (...) branch. So it's a time when probably you have come to us at the peak of pressure, plus the semesterisation. But on a scale of one to ten we are probably at ten. (...) think it's still a healthy course. When I said the pressure is ten, I wouldn't like to think that you'd think we are all dropping into pieces, we're not, but the pressure is at the point where I don't think we can take any more...we can not allow ourselves to make any more innovations or...at this point.*

But challenge can be sustaining. For although cultures which allow for innovation can make heavy demands on individuals and groups, because they are structured to encourage initiative and change they can also be rewarding.

> *I think if you asked every single teacher they would say they have never worked so hard in their lives. They would probably say they had never enjoyed working as much as they do now because it has been great (...) I wouldn't like to think that you'd think we are all dropping into pieces, we're not, but the pressure is at the*

> *point where I don't think we can take any more... we cannot allow ourselves to make any more innovations ... at this point*

5.3 Structures for course management, organisation and communication

The traditional way of organising staff is into clearly specified, hierarchical and bounded roles. Recent management theory has challenged such a conception as being inappropriate to environments which are undergoing continual and progressively rapid changes. The alternatives suggested include flattened structures, team organisation or task groups which emerge only during the life of a particular task. Under this latter form of organisation, stable and formal roles do not make much sense. Rather, individuals are seen to be members of several teams, handling 'portfolios' of responsibilities. It might be expected that if the traditional remains an organising force, it may well conflict with the emergent trends and lead to a felt sense of tension and frustration.

Within a traditional perspective, the key course management roles are those of course leader, leaders of parts of the course (for example common foundation programmes, branch leaders, year or group leaders), and course specific or cross course portfolios for admissions, examinations etc. In midwifery there is the additional role of the approved midwife teacher (ENB 1993 :3.68-3.70 in ENB 1993-1995).

Where staffing for an undergraduate course is small and focused predominantly on the course, as opposed to wide range of roles across courses, benefits and disadvantages are perceived by staff and students. Although there is often a sense of cohesion within small cohorts and small staffing numbers[3], simultaneously holding a number of roles creates pressures on staff:

> *...most members of the course team have some sort of leadership role. Either because they're running a branch or whatever it might be. If you're not there you need someone else in your place therefore...well more than let's say one and a half, two equivalent people to be away at any one time, could (...) now the course is up and running, could actually put a lot of pressure on remaining staff, (...) just for accessing students and the whole tutorial thing. I mean it's obvious really they're the things one should be there for. So it is a problem.*
>
> *I think it's also important that in terms of looking at the staff...staff position that you do actually have sufficient staff and sufficient staff base to ensure that people have appropriate breaks because with a 45 week the relentless umm...follow through of this, I mean it's true of the diploma as well but...classically it's been nursing colleges which have been involved in delivering the nursing diplomas which have very much larger staffing bases than many university departments (...) so this being considered within a university department you need really to be able to draw on a wider pool than just sort of you know four or five staff, umm so it certainly*

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[3] This model of undergraduate education is changing however as cohort sizes increase and mergers of institutions provide larger staffing bases from which a range of programmes draw.

> *would help if you had a raft of programmes and this is about planning for breaks for staff, particularly around admissions and those kinds of things alongside.*

Undergraduate courses which are larger, or where staff teach across a range of courses which include an undergraduate programme, pose different challenges for ensuring roles are enacted:

> *...probably as with any department you still find its the same few people doing the same things, but we're trying to help that by actually targeting people to do various things.*

Roles are often subjected to change as a consequence of departmental or faculty reorganisation, mergers and amalgamations. Lack of continuity within role can mitigate against the development of ownership of a course:

> *...the actual taking on the degree was imposed at the end of the day. I don't have any problem about it being a bachelors and about them being undergraduates, but I certainly did have problems with ownership, particularly when there are some things that I can see are blatantly not going to work, or going to cause problems. I'm actually responsible now...*

The sense of pressure is augmented when roles are ill-defined or open to constant re-definition:

> *...my role has changed, it changes almost termly. That's another problem we face, other departments have their time tables and I'm sure management would like to tell you, in fact I've got a memo today saying it's all gone very smoothly, and we've got our timetables, but the timetable changes.*

> *...(morale is) fairly low to be honest, I think individually people are committed and positive but there are uncertainties and ...and the difficulty of working with limited resources whilst not stopping the gates of floods of students coming in, we all sort of suffer from that. I mean looking at my own position, I'm certainly sort of... (I've) got three extra courses that I didn't used to have as opposed to two years ago and the requirements if that are obviously...the amount of time you are then in direct contact teaching hours leaves less time for other affairs and the whole administration of the department with bigger numbers, bigger classes, requirements for producing learning materials, it's all increased without...and in our own department the numbers have gone down rather than gone up (...) with people leaving and not being replaced...*

> *We've had a lot of staff changes. I don't think anything can be done about that. I think there's been a bit of morale problems around here for the last couple of years. But hopefully that will start to sort itself out for future intakes.*

Where curriculum design, development and delivery have been shared between cohesive and consistent teams, more harmonious working relationships and less pressured roles frequently result. The following extract from a lecturer focuses on successful service teaching founded on good working relationships which have developed over a period of years:

> *...because there has been a stability in those teachers, they understand many of them, ethics, psychology, they understand what the nurses want from that, they don't want to become biologists, they want to become skilled practitioners and those subjects are really important, so that's a great help.*

Where structures have changed substantially, roles, expectations and responsibilities have had to be redefined. This redefinition is made more complex by the fact that apparently similar structures can be articulated and experienced in quite different ways. Extracts from interviews with two course leaders provide an illustration:

> *...the head of department – she's ultimately, she's answerable for the course in a way because it's her department, so if there is a real mess then I suppose she carries the can, but she's delegated that down to me for the course. (...) She keeps telling us that the course leaders are the most important people.*

> *One of the problems, I think, within this department is power and information is not devolved, so that the head has a lot of power and a lot of information and doesn't...so nobody really knows how much anything costs. Nobody really knows how much the budget is and all of these things, so it's very difficult to say.*

Both have essentially a role based hierarchical structure. The first delegates responsibilities. The second keeps power in a way that is becoming inappropriate for the purposes of being adequately informed and empowered for decision making.

Role clarity and manageable workload are key issues mediating experiences of role conflict and pressure. The structuring of staff activity to produce the working environment in general, and the learning environment in particular, underpins both academic credibility and professional development. Whether they resolve into paradigmatic choices as management theory might suggest or whether it is simply a matter of developing a clear and agreed system that people feel comfortable with, having a full complement of staff is insufficient to produce the qualitative dimension. Both are necessary. The qualitative dimension will not emerge (or will be seriously compromised) if staff do not regard themselves as a coherent and purposeful group (see related principle 3.2 in Chapter 14):

> *You can suggest it's vitally important and things, but with some people there are changes that are happening and their wards are under threat and all kinds of things, their priorities might lie elsewhere, which is quite understandable at times, but frustrating from my point of view because I actually feel that it's so important that people participate (...) otherwise it isn't...otherwise what happens is when the whole strategic direction is developed and you get people saying, "Well I don't agree with this," and you know, "Why wasn't I consulted?" And it becomes an increasingly meaningless piece of paper because it really has only been a few individuals that have participated.*

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Increasingly, in the marketised provision of services, underlying all questions of management and resourcing are the fundamental issues of how much something costs and of how much income can be generated. A sense of the issues surrounding budgets can be gleaned from the following comments:

> *Nobody really knows how much the budget is and all of these things, so it's very difficult to say. In the faculty plan it did say that the Heads of Department would be responsible for the budget but I think if you ask our Head of Department she would say doesn't really know what's what. And the structural plan for the next few years said that it would be devolved down to course leaders, but I personally have difficulty in thinking that that will actually take place, but it is difficult.*
>
> *...for placements I've gone to whoever's head of nursing. So I would make initial discussions about money and courses – I'm not in a position to actually finally negotiate. I can suggest to them, "Oh we might be able to offer x, y and z" but then it goes (...to the Dean) and then I sort of loose sight of that which is quite difficult as well. So you know, a position where I have gone three-quarters of the way and then someone says, "Well hang on, that's it, you mustn't" yet I'm the one who's been contacted.*
>
> *I think one of the problems is not really knowing, not having a full picture about what's available, how much money there is, exactly how much people are prepared to support the course, really. I feel as though I'm sort of working on a basis where money won't be spent unless I've pushed for it...*

The underlying theme is that of 'not knowing'. This theme connects with the whole communications issue, which threads throughout this report.

5.4 Communication

Communication is too often conceptualised in practice in terms of 'transmission', that is, the transmission of information from a sender to a receiver. Contemporary studies of communication drawing upon semiotics and discourse analysis have shown the naivete of such a model. Communication has a creative role as well as a transmissive role. Interpretation of a message depends upon the codes available to the receiver to de-code the message. These codes are carried in the professional and lay discourses that people have at their disposal at a given time. Two professionals receiving the same message may not employ the same codes in its interpretation, particularly if they are from different professional groups. This has implications for the notion of 'effective communication'.

The intensive nature of undergraduate programmes demands effective communication structures. This at the very least entails the exchange of information and at best a dialogue between the parties involved. Structures have to facilitate effective communication without overloading course members and individuals in departments and clinical learning environments with an excessive volume of it. Changing roles and institutional structures present a challenge to the maintainence of communication which effectively achieves this balance.

The following kinds of communication process are most commonly experienced:

- ***Collaborative/partnership approaches*** where there is regular communication between the management of partner institutions of HE and the clinical sector.

> *(The service managers) are involved in our course management committees, people from the Trust come into that and the head of department meets them regularly in terms of communications and there is a whole set of committees in the college that senior members of (the university) staff attend.*

- ***Networking approaches*** where there are flexible lines of communication to reach the different groups involved in the undergraduate programmes:

> *We as lecturers work across the whole of the region, so we are in contact and networking. (...) We are out in the community, we are out there, we have those links. If you say to me you want to contact somebody at Infirmary hospital, I can ring somebody there and say, "Can you help me with this information?"*

- ***Transmission or 'top-down' approaches*** where frustration can result from poor communication within a faculty:

> *I think that's the biggest complaint in this faculty, that we – we communicate amongst ourselves at one level, but it isn't communication between the levels and certainly communication from the top is in terms of instructions, or, "This has been decided" or whatever. There is almost nil, I will say, in terms of negotiation, or ideas from the bottom going to the top.*

- ***Negotiation approaches*** where empowerment and ownership are nurtured by including all relevant groups within structures which are not restricted by hierarchy:

> *...I think a really good important point of this course is there is no hierarchy, it's just like the key thing is that's really helped the course along. Everyone is on one level, everything (...) everybody's got something to contribute and everybody's got something to learn and that goes from the top right to the bottom, you know. And I think really that's sort of helped everyone along. You know, the tutors, you'd talk to them like you'd talk to a pupil. There's just no hierarchy and that's great. And that lets...that enables you to sort of get right in there and get on with things rather than sort of going through the system.*

Creating the conditions for dialogue to effect ongoing evaluation of the course is a key aspect of communication explored further throughout the report. Without this kind of communication neither the symbolic nor the physical basis for a learning environment can be put together.

5.5 Where the action takes place: the physical aspects of the learning environment

All the acts which compose the lived curriculum have to take place somewhere. The physical dimensions of where it takes place matters. Just as the symbolic learning environment needs to be carefully nurtured so too does the physical environment. A physical environment is not neutral as regards learning. How the physical environment is arranged in terms of access to resources, comfort and flexibility to facilitate communication and meet teaching purposes can greatly influence a course.

In general, space is at a premium in all HE institutions. During the project, many institutions reported changing physical requirements as a result of mergers, amalgamations and intra-institutional reorganisations and developments. Relocation to improved or impoverished accommodation, and periods (sometimes prolonged) spent in temporary accommodation were also reported. For example, staff and students on one degree located in a fractured, multi site department eventually united under one roof, easing access for staff and students considerably. At another, plans to relocate one faculty from unsatisfactory accommodation were shelved due to a cash crisis within the university.

The transition to more suitable accommodation following institutional change is not always a smooth one, and interim, temporary arrangements were common:

> *But the distance away from the sites and then pulled into this big one which continues to heave and change is difficult. And for example the students, my group, are not happy about it because umm, when they applied to come here it was a campus university, taught in the central building and the campus, and apparently some chose the university because that is what they wanted. And then of course half way through the course they were brought here ,which still for all intents and purpose is really off the campus.*

Unsuitable working and learning environments exert detrimental effects on access, communication and morale. Conversely, where accommodation is allocated, built or adapted for the purposes of a particular group, the wait and inconvenience can be worthwhile if the centralisation of resources eases access and reduces the time spent communicating between geographically dispersed educational sites:

> *The fact that we are all on one site umm, is good and so it makes it very much easier for them to see their tutors when they are in the building; they can at least go along to the tutor's door and look at their timetable, book appointments, see them – and the library is here as well, so being all together has a great deal of advantage. It certainly has advantages for us as well, the tutors, we were happier to move into this building rather than being over a period of time when we had offices in one place and we were teaching in another place, that was very, very difficult. So that's a vast improvement. And then all of the services that are here in this building are good, the computing service, secretarial support which is good for us and the students as well.*

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However educational centralisation may be at the expense of access to, and communication with, clinical practice areas. As institutions amalgamate, circuits of clinical placements may be dispersed across ever wider geographical areas:

> *(The merger has involved)…dragging us away from the clinical sites so there's now quite a distance between places like New Town and Old City.*

Lecturers' access to clinical sites and on site-accommodation when visiting for teaching purposes or to support staff and students is often reported as a difficulty resulting from increased distance (both literally and metaphorically) between clinical sites and HE:

> *We had a place in the organisation. I'm very much aware now that I am a guest in the organisation. We haven't got that authority that we had...I have to ask the manager if I can send a memo round, she doesn't want me taking her midwives' time.*

This scenario is further influenced by market values placed on midwifery and nursing education, where the costs of access to accommodation in clinical sites are counted:

> *Because HE won't pay per capita changes for offices for us so we've got nowhere to put our bags…you wonder where the hell to leave your stuff, where do you see students and all these kind of things, and do you walk around with your handbag all the time?*

The threat of losing well established and effective working relationships and the potential breakdown of communication, can lead institutions to remain in inadequate educational accommodation within the clinical site. The value placed on the quality of learning resulting from close proximity with the clinical areas is clear. Two institutions described their situation as follows:

> *Lack of office space creates difficult working conditions. and during busy periods, it is sometimes impossible to find privacy for discussions of a confidential nature. Despite these problems, the teaching staff are very concerned about the possibility of removing the teaching centre from the hospital. The advantages of such a move are seen to be grossly outweighed by the disadvantage of; losing day to day contact with practice colleagues, being no longer able to provide an immediate accessible resource and source of support for students and qualified staff within the hospital' distancing of students in the classroom from the practice environment. (They currently are able to make the best possible use of both, because they are on site, and can make visits during breaks in classes, or be called into the practice are at short notice to make the most of practice environment opportunities as they arise.)*

> *...our biggest problem is that we are desperately overcrowded. There's no room anywhere in the Trust and we've exhausted all our available sources of space.*
> (However....)
> *....we also have the advantage of the best clinical nurses to do quite a lot of our one off lectures for us. So for example when we're discussing AIDS or problems associated with infection and AIDS, we have our infection control officer who lives*

> *around the corridor, I know her personally, I can give her a ring and she can come and do that. So we have good informal links with professional colleagues around this particularly large hospital.*

5.6 Material academic resources

Reports of the quantity, quality, currency and availability of library materials and electronic resources for learning and communicating vary between institutions. Excellent library facilities were reported by students and staff (and were observed) at institutions where effective collaborative working relationships had developed with a librarian with a remit for health related resources:

> *Like you get told to look and you think, "There'll be nothing on that," and then it's there, it's really good.*
>
> *...I got about 30 inter-library loans, just photocopies and they send them all to your house. And you don't have to pay, it was really good.*
>
> *The library is really, really good, there's so much stuff in there and journals as well, there's journals for years so you can go and have a really good bash at it. It's better to have a whole day off rather than just a morning or just an afternoon. (...) they have got all the computers, the computer points and it works on a system where you can just put a key word in the computer and it comes up with a great long list of titles which is great. (...) I think it's open form 8.30 in the morning until 9.30 at night pretty much everyday, and then weekends it's 11 'til 5, so you can really have a bash at it.*

Library facilities at other institutions where they did not cater for the particular needs of undergraduate nurses and midwives were not held in such high esteem:

> *The university library as well is very difficult to use, I can't stand it, it's so enormous and it's very complicated and it's very behind the times, still it's partly a manual and partly a computerised catalogue, so you have to look in two catalogues for everything. And nursing is the most difficult. If you're a psychology student you just go to psychology, that's no problem, but nursing, you've got to go here for nursing, there for sociology, and the library is sort of various blocks of buildings round a central block so it's actually going into different buildings and there's books in one place and the journals in another place, and then the current journals in another place (...) so it's very frustrating and time consuming to use the library even if you've got time, if you haven't got time then forget it..*
>
> *I mean I've got two strategies. One I spend about £250 a year on subscriptions and get the magazines myself (...) and the other thing is (...) I just take an away day down to London and I go down to the RCN library and I do in two hours what would take me a week to do in the library here.*
> Student

For students on professional degrees, there is an additional access issue. There is the question of how well library services dovetail with the needs of those students whose full timetables incorporate periods of clinical practice, and shift-work, sometimes making access to services difficult:

> *There is a problem with the library when they are on placement because the short loan collection, you can borrow overnight but you have to return by nine o'clock the next morning, and if you don't it's (...) a pound an hour fine or something like that, we have got a special arrangement for nursing students to take it back later and not pay a fine.*
>
> *There's also a problem with vacation opening hours because of the extended terms. Roundabout the end of June the library goes over to vacation times and our students are still here and for some of them, because it's coming to the end of our term, they need to do course work and they need to do their dissertations, they need the library to be open in the evenings and so on, and we negotiated as many concessionary arrangements as we can for that but of course a lot of the problem is paying the library staff to keep the library open and with a big library like that, you know, you've got to have about ten people to keep it open a bit longer so that...there's quite a lot of issues involved.*

And there is the issue of undergraduates' access to local hospital based libraries. As undergraduates have honorary contracts for supernumerary practice based learning within individual Trusts, and are neither employees or diplomate students providing a service contribution during their course, borrowing rights nay be refused or restricted:

> *...we can only use the hospital library for reference, we can't take books out.*

5.7 Summary

The focus in this chapter has been on the management superstructure on the education side which co-ordinates, communicates, orders and allocates resources in relation to student selection, staffing and curriculum construction. It has shown that degree level courses are seen as attractive options to potential candidates, and motivation to study midwifery or nursing with the intention to subsequently practice is very high. At the same time it has shown how pressures and local circumstances can militate against the intention to broaden access and create greater equality of opportunity. In such circumstances course providers may feel increasingly less able to 'take risks' by recruiting students who, while they are able and motivated, are from non-standard educational backgrounds. Programmes which succeed in mitigating the worst pressures of rapidly expanded cohort size and increased demand on resources for teaching and academic support, have adopted key structures to create an optimum learning environment. These include structures for improving recruitment processes and increasing equality of access.

The staffing of undergraduate programmes emerges as a key management/resourcing issue in terms of a) securing and maintaining adequate staffing numbers which recognise

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the professional element of the degrees, b) facilitating ENB requirements for nursing and midwifery lecturers to maintain contact with clinical areas, and c) planning for the sequential employment or deployment of staff as courses are established and all student years are operational. From within the same set of limited resources institutions must also a) attempt to develop academic and professional expertise, b) ensure stability and the continuity of staffing, and c) arrange for clearly defined and manageable roles which decrease the likelihood of excessive role strain.

Part of the management task is to negotiate with the HE institution for adeqauate and appropriate physical accommodation. Access to private spaces is essential for academic and personal discussion between staff and students taking professional courses where reflection on practice is a central requirement.

Access to high quality material academic resources such as library facilities, multimedia, computing, IT and AV equipment varies between undergraduate programmes. Development of good working relationships between library, computing and technical support staff and nursing/midwifery lecturers and students are required to ensure that services and resources are responsive to needs of the undergraduate programmes. Access during extended academic terms is a key requirement.

In brief, facilitative and empowering structures are needed for effective course management, organisation and communication, together with time, space, human and academic resources for initial implementation, ongoing development and evaluation of the curriculum. These structures must be responsive to changes resulting from the implementation of a new curriculum.

CHAPTER SIX

Resources for quality in clinical learning

Introduction

Quality in clinical learning is central to the whole strategy of professional development from student to experienced professional. Institutional structures should be constructed, therefore, as a service to the management of learning and not as an imposition upon it. This seems obvious. Yet, it is easier to say than do. Although quality is affected by the the extent to which institutional structures *serve* learning, the nature of the learning experience itself - and the theories of knowledge which it embraces - is also very important. In this chapter we offer evidence of different resource constraints on students' clinical practice experience, and explore the implications for the development of theories of knowledge which may be appropriate for encompassing, growing from and understanding practice.

This tension between *service to* and *imposition on* the processes of clinical learning is a recurrent theme. The actual clinical placements secured for the purpose become the stage upon which learning performances and their management take place. Hence, the placements secured and their quality are critical to the development of appropriate learning processes. This is just as true for experienced clinical staff in terms of their own professional development as it is for students.

6.1 Securing quality clinical placements

Ensuring the planned provision of quality clinical placement for student learning is an essential requirement for course operation. This has emerged as a problematic area for some undergraduate nursing, and to a lesser extent midwifery, courses. Difficulties encountered centre on both the particular position of undergraduate programmes in the larger arena of pre-registration nursing education, and on the general issue of ensuring that the provision of clinical placements of suitable quality meets learning needs of students.

In line with current professional requirements laid down by the ENB, the selection of clinical areas is negotiated by teaching staff, clinical staff, managers and occasionally students. The suitability and quality of each placement is determined by educational audit, which occurs at least annually (ENB 1994 p 2.5 in ENB 1993-1995), supplemented by clinical liaison, evaluations and feedback.

Changes in the organisation and delivery of client care and the educational vision to facilitate students for professional registration have created new demands for clinical placements. Project 2000 style diploma and degree courses place increased emphasis on

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community based care. The growth in pre-registration midwifery education poses fresh challenges as students must develop clinical competence in midwifery without a prior grounding in 'caring skills' associated with registration as a nurse.

As a consequence of the complex practice requirements of midwifery students (studying at diploma and degree level), large numbers of pre-registration nursing students on the branches of Project 2000 diploma and undergraduate programmes, enrolled nurse conversion courses, and post registration students on specialist courses, centralised systems are required to allocate and co-ordinate clinical placements. These mechanisms aim to ensure that staffing and resources in individual clinical areas are sufficient to meet the educational needs of the numbers and mix of students allocated, without compromising client care. The central systems, which usually also co-ordinate educational audit activities, are based in educational establishments and span wide circuits of hospital and community placements. Where a number of institutions use similar local circuits for clinical placements, shared systems (usually based at the larger institution) ensure that the presence of students in clinical areas is controlled.

Some undergraduate programmes are located in HE institutions with in-house placement allocation and auditing systems. Others (often more mature programmes based in smaller university departments which have not integrated or amalgamated) share the audit and allocations systems of larger local provider institutions of nursing and midwifery education.

Where an undergraduate course has access to another institution's allocations system, arrangements are not always problem free. Lecturers and students express anxiety and cite evidence to support their concerns that undergraduate students are marginalised within some local systems. In highly pressured and competitive local placement circuits the learning needs of undergraduates are vulnerable where they are perceived as 'outside' users of the allocations system. Where undergraduates receive the last pick of clinical placements, clear threats are made to the quality and relevance of the clinical learning on offer:

> *There is current pressure on placement areas to take students as the number of clinical areas has reduced. Well it's the same here as it was in Newtown, and I worked in Oldtown so I know what it's like there, (and) I've no reason to think that it's any different anywhere else. It is pure hell, it's unbelievably awful because you have no rights in the placement areas at all, you only get placements by grace and favour so you have to do a hell of a lot of well public relations type work. And they say, they don't only say it to us, I've even heard them saying it in front of ENB Officers, "We place our students first, and then we place your students," or words to that effect, even though our course is validated jointly between the university and the hospital and their names are on it and they had to undertake to provide the placements. Well that's all well and good for the day of the validation but after that it falls by the wayside.*

As a result of competition between courses and institutions, students may encounter difficulties in meeting curricular requirements:

> *...it might be, say, at the start of next term where they do medical nursing, that the college gives to me a range of specialities which may not be my first choice of specialities, and then we would share that out amongst the group. So I might in the first term want – because that is the nature of the theoretical work – I'd like to see wards that are say respiratory wards, because there's a lot of basic ideas about nursing and about physiology and connecting together things. Now if those wards don't come, there's nothing I can do about it. If I get a whole set of oncology wards, well I would deal with that at the time.*

As these cases highlight, placements are becoming scarce resources subject to the politics and economics of supply and demand.

6.1.1 The effect of markets on clinical placements in nursing and midwifery

A consideration of the origins and development of undergraduate nursing and midwifery alongside the mainstream routes to registration provides insight into the current situation. Historically undergraduate nurses have been educated in small numbers, additional to local and regional requirements for newly qualified staff. Degree programmes were established firmly within HE, receiving monies predominantly from education as opposed to health budgets. Undergraduate students were supernumerary in practice, and honorary contracts were negotiated for the relatively small (and hence more easily accommodated) numbers to gain clinical experience in local NHS settings. Relationships to secure clinical placements for undergraduates were frequently characterised by goodwill; the work involved in teaching, supporting and assessing undergraduate students was traded off for what was regarded as the prestigious and intellectually stimulating contact with the university.

In contrast, larger numbers of salaried student nurses on certificated courses (forming part of the NHS workforce), and more recently Project 2000 student nurses, receiving NHS Bursaries and contributing 1,000 hours of educationally led rostered service contribution to practice (ENB 1994p 3.78 in ENB 1993-1995), have been funded in order to meet requirements of local and regional manpower planning. Relationships between the NHS premises and local schools (latterly colleges) of nursing and midwifery or health were typically geographically close and financially interconnected.

In midwifery, the introduction of undergraduate and diploma level programmes have coincided with an expansion of pre-registration courses (see Chapter 2). Pre-registration degree programmes follow the same lines as their nursing counterparts in that they are located in HE, and most students are eligible to apply for a LEA grant and are supernumerary in practice[1]. In contrast, pre-registration midwifery students studying to diploma level receive NHS Bursaries and are required to undertake 1,000 hours of rostered service contribution` during their course (ENB 1994 p 3.64 in ENB 1993-1995).

The introduction of markets governing education for non-medical health professionals outlined in the NHS reforms (DoH 1989a) and developed in subsequent policy (NHS

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[1] In only one exception in midwifery do pre-registration undergraduates receive a non means-tested NHS bursary (see Chapter 10 for further details of student finances).

Executive 1995a; NHS Executive 1995b) have firmly established purchaser and provider relationships between the NHS and institutions of nursing and midwifery education. Following legislation to abolish the Regional Health Authorities and create Regional Offices (NHS Executive 1994) , education and training of non-medical staff is devolving according to the general principles of employer responsibility for local workforce planning and intake levels to education and training programmes, and the formation of consortia of health care purchasers and providers in NHS and non-NHS sectors to hold budgets and contract non-medical education and training from educational providers (NHS Executive 1995a). With guidance from the NHS Executive, consortia should be established in 1995/6, so that purchasers and providers are able to operate under the new directives from April 1996 (NHS Executive 1995b).

Pre-registration undergraduate programmes have traditionally occupied ambiguous positions in NHS funding and contracting for nursing and midwifery workforces. Although support for undergraduate courses is secured at regional and local levels prior to validation, few are 'purchased' and their funding bases vary. Most, but not all, undergraduate courses predominantly rely on HEFC funding; some courses receive substantial funding from the NHS at regional level. Informally undergraduate courses have often benefited from sharing resources with (often larger) institutions where courses are funded by the NHS, or by being granted access to NHS resources in the form of support for students in clinical settings. Such informal arrangements are reported to be increasingly vulnerable due to the market oriented approaches in the purchasing of nursing and midwifery education.

As the majority of undergraduate courses are not contracted to, or purchased by the NHS, manpower planning at regional level has typically acknowledged numbers of undergraduates 'in the margins'; i.e. in order to balance manpower needs and the availability of suitable clinical training areas (particularly in midwifery and the smaller branches of nursing such as paediatrics where overcrowding is detrimental to client care and student learning), the numbers of undergraduates in training locally are acknowledged, even when not formally contracted for.

The ambiguous position occupied by undergraduate programmes within the current purchasing ethos of education brings freedom for some (for example, allowing them to not feel restricted by local clinical provision and to cast a wide placement net to secure clinical excellence and specialist experience), while others face fierce local competition with more formally contracted pre-registration students to secure clinical places.

In order to ensure the delivery of high quality clinical placements when undergraduate programmes are outside formal contracting systems, most institutions barter post-registration education in return for the supervision of undergraduates. Nevertheless, some goodwill relationships are eroded by the economic realities of the day:

> *Well, what I've found is that with Project 2000, because there's a contractual obligation, therefore there isn't too much of a problem in terms of placements, it's a sort of hand in hand thing. But a degree is seen as an extra and people are sort of saying, "Well what's in it for me?" and they're very much viewing it, "This is going to cost me in terms of time and my staff, and when am I going to get any pay-*

> *back out of this?" And the answer is in the short term, they don't get any pay back out of it. (...) For a few places (...) we've had to get into the payment, whether it's in terms of money or in terms of offering courses. So really I think it's because there just isn't any obligation.*

> *I've negotiated with that manager on bended knee to take another three (students) this year. Now to get her to take another three next year, it's costing me a lot in terms of the amount of work I am having to do for her...professional education, getting her midwives through degrees ... but she said to me "You know this is the pay off." She is only letting me have students there depending on what she can get.*

At its most extreme, the 'costs' of supporting learner nurses can be viewed as an unwanted, additional 'burden' as opposed to a valuable asset:

> *Many managers of service could live quite happily without students thank you, because, "Somebody else will train them, and they make my nurses less efficient because it takes more time if you have got a student with you." It's short-sighted because you will result in stagnation. I think we need to look at the added value issue of, "If we have access to your clinical areas for our students, we will do clinical updating with your staff."*

But the facilitation of student learning need not be an 'add-on' activity which slows a practitioner down in the delivery of health care (See Next Section and Chapter 7).

Financial 'arrangements' for placement opportunities are in conflict with policy recently outlined in NHS Executive planning guidance for 1996/7 educational commissioning for non-medical education and training (NHS Executive 1995b). Under the priority, 'To secure sufficient clinical experience and supervision for students in practice placements to enable them to achieve specified learning outcomes and professional competencies' (priority 7), the following statement is made:

> *It is NHS Executive policy that NHS bodies should not charge for clinical placements which form an integral part of non-medical education and training programmes. In the small minority of areas where charging currently exists, it is being phased out. Aside from the overall objective of training sufficient health care professionals to meet the needs of the service, the allocation of students to clinical areas brings other benefits and distinguishes host bodies as dynamic organisations. Health care purchasers should recognise this important contribution and may wish to question the validity of NHS bodies which fail to contribute their fair share to health care professional education.*

It is anticipated that adherence to such policy, as enacted through the following action point, will alleviate problems associated with ensuring the delivery of clinical placements experienced on some undergraduate courses visited by the project:

> *Education commissioners should ensure that all health, and where relevant, social care organisations are meeting their obligations to provide high quality clinical placements for health care students.*
> (NHS Executive 1995b point 7.4)

Numbers of pre-registration undergraduate nursing and midwifery students are set to rise. In light of pressures and competition for clinical placements, and the growth of pre-registration undergraduate programmes alongside diploma level programmes, there appears to be a pressing need for more detailed examination of the position of undergraduate nurses and midwives in the emerging marketplaces of local commissioning, to ensure that they are not disadvantaged. The enactment of good practice related to clinical experience and supervision of students in practice (NHS Executive 1995a; NHS Executive 1995b), and greater dialogue between the stakeholders of nursing and midwifery education (Department of Health 1994: 10-11) will hopefully ensure that the position of undergraduates is no longer marginalised.

6.1.2 Changes in the delivery of care – effects on student learning

The changing health care needs of the population have resulted in new forms of service delivery. In response, pre-registration nursing education courses now exert greater demands for certain types of placements, in particular in the community and specialist services such as child health, mental health and learning disabilities. Bottlenecks are reported in some localities:

> *I think a lot of the ward areas, community areas just feel overloaded with so many students passing through the areas continuously with Project 2000, that they just think, you know, "We can do without this thank you," really. Not everywhere, some places are very excited, want to have undergraduates, but at the moment it's very hard work.*
>
> *It's about rethinking the role of these placements in the undergraduate courses, and lots of people are doing that. It's not appropriate perhaps for people to just go out with health visitors and district nurses – it need to be much more self directed in terms of those particular placements.*

In midwifery, reviews of the organisation and delivery of maternity care (House of Commons 1992; Department of Health 1993) are resulting in a dynamic and diverse range of service models. These include team midwifery in hospital and community, hospital (or hospital-and-community) integrated teams, group practices and Midwifery Development Units. These are having significant impact on the type, range and number of clinical placements available to students:

> *With the midwives going into teams, the way that they're running these teams and structuring the work, we cannot put the same number of students in these hospitals or communities.*
>
> *We've got nine teams for instance at Newtown and they can only take one student each because of the way that they work.*
>
> *...there is huge competition for clients.*

In addition, Changing Childbirth, the Report of the Expert Maternity Group (DoH 1993, p 42) anticipates a more formal role for experienced midwives in the training of Senior House Officers. This creates further demands upon competitive maternity learning environments.

In such circumstances, students' learning requirements are clearly marginalised by the organisation of client care. When placements are not delivered, the extra workload created for staff seeking appropriate, alternative placements – often at short notice – can be huge. In conditions of such pressure there is little if any time to think about the relationship between placement area and curriculum. Yet these are circumstances well beyond the control of course providers. That there must be negative effects on the secure development of learning environments is clear.

6.2 Preparing clinical staff for mentoring and assessing

This is ground that has been discussed at length in the ACE Report (Bedford et al 1993). The ENB has drawn upon aspects of this report to present its recommendations guidelines for assessment (ENB 1995 p 5.1-5.32 in ENB 1993-1995). The findings of the TYDE report overlap with these developments and thus time has not sufficiently elapsed to record significant changes as may be expected. As argued in the ACE report, preparation of staff is critical to the development of an educative learning environment. This is no easy task. The conditions described in this chapter see to that. Exhortation is clearly not enough. No matter how good the guidelines or the recommendations there is a resource base line that must be achieved.

The ACE report argued for a dialogic approach to education. This means that the *relationships* between *all* parties are critical in the development of a learning environment (See Chapter 14: 6.4). Hence, structures for communication and dialogue between staff working in HE and clinical practice must be established and nurtured to facilitate student learning and develop shared ownership and commitment to the course.

The recently redefined roles of assessor and mentor are as follows:

As assessor is: *"An appropriately qualified and experienced first level nurse/midwife/health visitor who has undertaken preparation to develop skills in facilitating student learning, supervising practice and assessing the student's level of attainment related to the stated outcomes of the programme."*
(ENB 1995: 6.3 in ENB 1993-1995)

A mentor is: *"An individual who has an understanding of the context of the student's learning experience and is selected by the student for the purpose of providing guidance and support."*
(ENB 1995: 6.5 in ENB 1993-1995)

Role preparation for mentors usually takes the form of a short in-service course, far less intensive than the requirements to fulfil the role of assessor (i.e. the ENB 997 for midwives and ENB 998 for nurses – 'Teaching and Assessing in Clinical Practice' course, or equivalent.) The quality of mentorship and assessment in action is explored in Chapter

7, Section 7.7. It is worth noting here however, that availability and quality of educational preparation for mentors was raised as an issue by some clinical staff who felt ill-prepared for their role; shortage of mentoring staff frequently precipitated this situation:

> *But when I came back to work (after 2 years away) I was a mentor straight away, and had to cope with the computers and the degree student and I hadn't done the preparation sessions.*
>
> *I did not manage to get on this course due to staffing levels, and things were tight so I had little preparation really.*
>
> *I asked to go on a mentor study course which was two days and I went to anything that had anything that was on mentors at the time, umm it doesn't prepare you really for passing on knowledge.*

As the above extract highlights, establishing structures to facilitate clinically based learning components of new or revalidated courses is essential. Clinical staff require information on the overall structure and aims of the undergraduate programme, as well as more detailed knowledge of the learning experience they will be facilitating and their role in mentoring or the assessment of practice. As students require experience in a variety of clinical settings throughout their course, lecturers must access large numbers of practitioners to disseminate information and empower practitioners for their roles. Establishing and maintaining such contact requires significant resources. Where course development and implementation are hasty, the period for preparation of the clinical staff is limited.

The preparation of mentors and assessors is not a one off task. It is a process that requires a reflective cycle within the workplace:

> *..that's been quite an intensive process to make sure that anybody who is supervising in a rolling way through the course as the pathways unfolded could be prepared. And that was by no means the end because we found that with that (first) cohort in particular, much of our clinical hours were wither being taken up or exceeded by supporting supervisors. And clearly there are gains in that with the second and subsequent cohorts. That has been a lot less intensive because you know they've been more familiar. But that was a very important and intensive area of work I felt which couldn't be avoided, and we have had to see many hundreds of supervisors through those two days programmes and also do a lot of follow up work at clinical level in the community and in the hospitals, you know. And I think that's been at the same time as the course team have been delivering the course, umm, it's been a very steep learning curve for all parties you know.*

Lecturer practitioners and staff holding joint appointments with significant and explicit clinical roles are in a better position to assist greatly in this process, as they are able to devote more time to developing relationships with clinical staff and facilitating undergraduate learning. (However as Chapter 7 reveals, role pressures may restrict this activity.) At one university, withdrawal of funding for a lecturer with a high clinical remit in her role reduced the quality of preparation for clinical staff prior to the arrival of students on placement:

> *...for example she used to write the letters to the ward saying that students x, y, and z are coming, now the year tutor does that. So the work has been shared. In the same terms she used to go and visit the wards before the students arrived just to prepare them, saying, "Here's the assessment book," talk them through it. Now I have to do that by letter and telephone, obviously that's not as good a quality product as Jenny going out and saying, "I'm from the university." The first time they see me is when I go out on a visit...*

Keeping clinicians up to date with new initiatives such as undergraduate courses or a move to pre-registration midwifery, and subsequent changes once the courses are up and running, is a dynamic process. Clinical placement areas and their staffing complements are not static, and changes and developments to the undergraduate programmes need also to be effectively communicated. When communication involves new or changed philosophies, practices and beliefs 'telling' is insufficient. Shifts, however small or tentative, in perceptions, 'paradigms' or world views do not come easily:

> *...it has been quite challenging to enable the clinical practitioners and local managers to cope with the demands of an entirely reoriented form of education, both the diploma and the degree level, and to cope with the numbers of both levels at the same time. And so we've had to do quite a bit of fancy footwork I think in terms of preparing supervisors, particularly for the degree.*

The extent of the challenge can be gauged when it is realised that what is being confronted is a culture:

> *I think it's a change of culture too because the supervisors are used to having a student who's primarily based in the clinical area or a department or a ward or a setting and in fact we're encouraging the students to be much more linked to an area but free to learn from a wide range of others, you know. And that's been a change in culture which the community, the general community has helped us particularly with ,in sort of saying , "Well OK, someone's got a base area but while they're here we want them to see as much as possible to do with this client's setting of that group," and encouraging them to sort of do the kind of work we mentioned before like following the OT to the home to do a needs assessment, bringing the client back into the ward, seeing the person in the community, you know with the GP you know, being much more mobile as the client and their family and their carer is.*

The problem here comes from considering learning as something distinct from caring, something to be added on, or attended to in the margins of day-to-day activities. Part of the problem is in seeing learning as something that *only* students do and hence that it is an additional responsibility for professionals when they take on a 'teaching role'. This stems from the language of the 'old' culture which saw education or training as something which precedes becoming qualified and ends at that point. The situation changes when located in the new discourse of professional development as a) a lifelong activity and b) a process of continuous reflection upon practice in order to test, extend and develop knowledge and practice. In this changed perspective clinical care and education are not separate activities carried out by separate staff within separate physical locations. They are interdependent: they are inseparable dimensions of the same process. Within the process of care are the same dimensions of learning about the client's needs in ever wider contexts of action (see Chapter 7 for a more detailed discussion) which students must learn.

Such changes are cultural, personal and professional. Professional development is not simply an add-on but a necessity as a competent professional continually strives to re-newthemself, their practices and their knowledge base. Being a student is only one phase in the whole process.

6.3 Summary

Chapter 4 discussed the role of the 'ideal' in relation to the pragmatic in the development and delivery of degree courses. The concerns expressed in this chapter focus upon the extreme pressure points which further limit the development of degrees in their practice dimensions.

By and large this has been a story of how conditions – personal, cultural, economic and material – often impose upon the learning environment rather than serve to produce a quality learning environment that is integral to the processes of caring. Principles 2.1; 2.2 and 5.1 in Chapter 14 have key relevance here.

Ensuring undergraduates have access to placements that facilitate learning as integral to caring is a difficult task. Since all student nurses and midwives are required to complete substantial periods of clinical experience for professional registration, there is a danger that competition and changing circumstances mean that placements for graduates are not allocated out of choice, but out of desperation to place a student somewhere. Concerns surrounding arrangements for nursing and midwifery undergraduates highlight the need for a greater debate regarding the issue of securing high quality clinical placements for *all* nursing and midwifery; calls for greater dialogue between stakeholders of midwifery and nursing education are endorsed (Department of Health 1994: 11).

There is an urgent need to ensure that mechanisms for securing quality clinical placements are effective; that commitments of clinical partners from management and grass roots level are delivered; and that declarations of shared ownership at the validation stage are subsequently evident in the quality of student teaching and learning. At the point of student learning this necessitates:

- ensuring provision and quality of clinical experience to meet the varied needs of large numbers of students from a range of courses;
- sufficient numbers of staff are qualified as assessors and mentors
- initial role preparation and ongoing dialogue focusing on the experience of mentoring and assessing undergraduate learning;
- effective communication and dialogue between education and practice areas directed at:
  - the development of the integration of learning and caring environments;
  - ongoing dialogue so that proactive discussions and decision making can be made regarding clinical organisational changes which have an impact on student allocation and the learning experience.

CHAPTER SEVEN

Creating the conditions for clinical settings as learning environments

Introduction

Given the vision of the reflective practitioner, the nurse and midwife as problem solver and as research-based practitioners, the creation of a learning environment, it has been argued in Chapter 6, is not an add-on to the process of caring but is integral to it. This chapter builds upon the model of the learning environment introduced in Chapter 5 as it continues the themes of Chapter 6 by considering the processes of innovation.

Features which figure prominently in any discussion of innovation in practice include:

- the role of occupational culture in relation to institutional conditions;
- changing roles, practices and identities leading to on the one hand a sense of loss, de-skilling, de-valuation, and on the other, progress, improvement, empowerment, enrichment;
- the role of dialogue, participation and shared responsibility in team building and formulating both individual and common courses of action;
- investment in change and development.

7.1 Where students learn – clinical cultures

Occupational culture is dynamic, complex and heterogeneous. It is a major resource for any professional. It provides ways of categorising, theorising and acting in immediate circumstances as well as strategies to develop and change over the medium and longer terms. It is a source of advice, knowledge and even comfort. Every individual contributes to its development and transmission to others. Its strength is its basis in practical wisdom; its weakness occurs when it is unreflectively or fearfully conservative:

> *The barriers are, a lot of midwives don't want to change. They've been practising in a certain way and don't want to change. (...) midwives who don't want to extend their skills or they're working in a narrow field and feel nervous about extending their skills.*

Since occupational cultures vary enormously, at the other extreme:

> *There's a tremendous room to innovate. We're um, one of the most striking thing about the unit, to an extent the hospital also, is the culture whereby innovation is valued, that research and scholastic endeavour is highly prized….we have a philosophy that's very patient centred, that it's the primacy of the nurse patient relationships that values things like patient education and empowerment through for example a self-medication programmes, literature, we have a specialist support nurse that visits patients at their own home, prior to them coming into hospital (…) I think there is plenty of room for innovation, primarily because the philosophy will allow for it.*
> Lecturer Practitioner

In between there are cultures which are facing challenges coming from innovations in education which they are learning to live with, even change with:

> *…people are used to having a higher level of academia in students. And they've come to terms that the students are there to learn, are more questioning. I mean when the degree students first came and they said, "Why?" It really upset the good clinical nurse because they knew roughly why, but couldn't explain why things took place. And the whole culture within the hospital has changed and now everything is research, not everything but we're trying to make things research based. We're trying to make the qualified nurse read more, develop themselves more and question more. (…) So everybody's grown. And it was I think approximately the onset of… the degree was probably one of the catalysts for change.*
> Senior Clinical Manager

Critical to such changes and developments are the structures which facilitate dialogue between professionals:

> *…we have a nursing development network where we ask people who are doing things out in the practice areas to come and (…) talk about it, so that the students come and the staff come.*

However, to make such structural and cultural changes happen investment is required.

7.2 Investing in change

Earlier chapters have already emphasised resourcing issues which pose constraints. There is thus the issue as to whether in the contemporary market climate, purchasers of health care will take on the costs of education:

> *I think we've under-invested in, in research within the city for nursing in particular. We've recently taken up, or have jointly funded a nurse with the university, which I think is a major step forward for us… but it's how you ensure that what happens at that level comes back to into practice. And I think what I'd like to see is, is much more local control within us as a unit to, to take on small scale research in order to inform practice. Umm and maybe the more degree nurses that we have within the system, the more likely (…) we are able to influence the directors*

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> *of care to give us a few hours of somebody's time…because we don't have a budget. I have to go and convince someone to give me something and I have to be able to describe the sort of benefit that may come of that…*
> Senior Trust Nurse

The issue of resource becomes acute when research is brought into the picture:

> *…so you go to purchasers and say, "Well this is our range of overheads that go with the service," and they go, "Oh hang on a minute, you've taken fifty grand out a year for research. Well we don't know how much of that we want to purchase." And we have to recognise that purchasers are making very, very hard decisions these days given their financial allocations and one of the things that is likely to suffer is education.*
> Senior Trust Nurse

This raises the whole question of the extent to which a professional is a 'product' and the extent to which purchasers should define the product. Explicit in market doctrines is that the consumer/purchaser is sovereign. The implementation of Working for Patients (DoH 1989c), the Patients Charter (Department of Health 1991) and subsequent and related acts have resulted in fundamental changes by putting mechanisms into place which effect a quasi-market with customer 'sovereignty'. However, this is made complicated in that patients-as-clients are thought of as the 'customer' then they are not actually the purchasers in this system. Rather the 'purchasers' are GP fundholders and Trusts who are in effect making purchasing decisions on the behalf of 'patients-as-clients/customers'. As such, they are in a powerful mediating position in setting the conditions under which 'hard decisions' are made. In the design of a learning environment and the vision of the professional that it develops, it could be argued that the ultimate arbiter is not so much the occupational culture of professionals but the managerial/financial cultures of given Trusts operating within a market culture whose customers are not in fact 'sovereign'.

Investing in change also relates to valuing and encouraging staff as valuable human resources and raises the question of whether it is important to increase their value through professional development:

> *...one of my deputies is also doing a, a masters. I've got two staff nurses who are doing BScs at the moment (...) and those that aren't are thinking about (it. ...) It's interesting because I've just, I mean I'm umm, been sifting through application forms for a, a deputies post, we're interviewing tomorrow, and every single one of the (...) applicants says (...) proposed future study BSc, MSc. They're all doing that I think primarily because of the groundswell of feeling that if you don't, you're going to get left behind.*
> Graduate Practitioner currently studying for a Masters

> *...my agenda is I think...has always been about continuing education for people... mean I'm not a young woman and having just done my MBA...I think shows a commitment that I have to...to continuing education myself ...and I would like to think that's something that I encourage in nurses generally. (... In) this*

> *organisation we need to continue to educate and invest in our nursing workforce...umm the easy bit is getting them when they're newly qualified, it's sustaining motivation, interest and learning after that ...that for me is crucial.*

Importantly, such investment in practitioners is seen as essential to encouraging climates in which students learning is promoted and valued:

> *It's very important to have a very good ward sister, there's lots of papers that came out in the '70s I suppose, about the key position of the ward sister and that's still relevant as far as I can see. It's about having someone that's going to take that, that... has the energy and the motivation to take things forward and to motivate others. That's the key thing. If you don't have that I think it's very difficult for people to umm...produce a good learning environment. What makes it is the workers in that environment challenge each other, they're motivated, they question, they care about their work and they care about the students (...) they're motivated to thinking about producing nurses for the future, that sort of thing.*
> Lecturer Practitioner

This suggests what is at stake in taking financial 'hard decisions': the quality of the professional learning environment for staff and for students.

7.3 The effects of 'hard decisions'

The impact of marketisation on practitioners ranges from positive experiences where creative and sensitive responses to recent and current challenges are facilitated by supportive management, to more negative outcomes characterised by turmoil, inadequate levels of funding and staffing, low morale and lack of empowerment. Consequently, when undergraduates enter community and hospital settings as part of their learning experience, that experience is framed by the political and economic conditions which have shaped the various settings managed by the Trusts.

The consequences of 'hard decisions' of course vary from place to place. However, one major effect can be seen in concerns expressed about the ability to plan and to resource appropriately. For example, a major problem has been the frequently expressed anxieties about recruiting staff, and senior grades in particular:

> *I think recruitment is now recognised as a problem, but it's one of those unfortunate things (...) had an effective strategy been put into place earlier then the problems that we are suffering now which are now hospital and country wide perhaps wouldn't as be as bad as they are. But now that we are in difficult recruitment times and everywhere appears to be, then it is much more difficult to get out of it.*
>
> *But actually recruiting people with experience you know, and expertise is quite difficult. It really seems to be a bit of a buyers market at the moment on that one. (...) The last round of recruitment we appointed five people and we only actually got, two of them came in the end, three got offered something else.*

This is a world of bank and agency staffing, of temporary and shifting employees with all the implications that has for the development of occupational cultures and the development of professional bodies of knowledge in general, and knowledge specific to particular clinical settings. It is not just staffing that creates pressure and impacts upon planning of course. It is the combination of resource pressures.

> *…the pressures on beds and so on has been quite hefty, and the pressure on resources and so on. Having said that I think (staff are) quite resilient, and the commitment, you know, I've had very little sort of faltering in the commitment towards the students and education and so on, but it hasn't always been the ideal environment. But then again, I believe that they should be exposed to the real world, 'cos that's where they learn most effectively, and I'm not saying bad practice, you know, and when they come to the wards there are things going on management wise and changes or problems, I tell them about it. I say, "You may get to hear these things but this is what the real world of nursing practice is all about."*

In this case, it can be argued that this is only what is to be expected in the real world and that students should not be shielded from it. However, the question must still be raised concerning the resulting quality of the educational experience when there are problems with the availability of experienced permanent staff having time for students when immediate patient care needs comes first.

In the model of the reflective practitioner it may be reasonable to expect staff to notice and intervene appropriately:

> *…on occasions on a ward like this, cardiac arrest for instance, obviously the patient and the relative take priority, but we wouldn't like to think that the learner went off unsupported totally, but certainly, yes, there are times when they are less well supported, I must be honest. Sometimes you come on duty and there's sickness and I think, "This is appalling." You think, well they've been scurrying around with one staff nurse between two teams, and it's far from ideal, but then I would say that happens in most areas, and certainly on a planned basis it doesn't. It's usually due to sickness or some other event, pressure of workload, for instance of you've got a patient who comes in who needs specialing – that takes one trained nurse out and perhaps whilst we'd like to involve the learner, it's not necessarily the experience she's come here for.*
> Sister

> *I think probably one of the biggest umm impacts on the education side is whether the ward staff appreciate education and whether they have the time to be able to support the students, and whether there is enough staff to be able to support the students. Because you can run the best course in the world, but if the clinical areas are under such pressure and you are under such staffing shortages, which must occur in every hospital, then it's very, it does get more difficult. I mean obviously it opens the students' eyes to what goes on in the real world, but you know … I think at the moment the students aren't compromised because I think on the whole the staff are exceptionally good about taking time to teach them, and to support them, but at what cost to themselves? It makes you wonder.*

At this point where people begin to 'wonder', if it is a choice between talking to a student or dealing with patient care, it is clearly right that the latter comes first. If that choice has to be made often, though, there is clearly a lack of educational resources in the particular placement area and thus questions should be raised regarding its suitability as a placement area[1]. It could also be argued that the student, if properly prepared for placement in accordance with the reflective practice philosophy espoused by the profession, could then apply learning strategies to this or any other situation whether or not circumstances in the placement area are facilitative. Through the application of learning strategies and supported by education staff, a critical curricula of the workplace could be accomplished through which the student learns about the realities of practice without being limited by them. This points to an important criteria concerning both educational support and student preparation for learning. (See Chapter 14, principle 9.1.)

Consider the implications of the following student statements:

> *I think different areas gave you different messages and certain areas have a lot of resources and funding, very highly motivated units that you would go on and most of the staff there felt themselves to be professionals and what have you, and they would give you that feedback. And then you would go to other units and maybe the morale wasn't so good, maybe there were problems within that unit (...) you knew there were problems, I mean you didn't understand why there were problems, but even as a student you would know when it wasn't a particularly supportive unit.*
>
> *I've had very good experiences where all the ward staff have been very good and supportive and the mentors have been really good. And I've been on other wards that just don't want you there and more or less tell you so, and you're glad to leave those because they just have no support. I mean not just because they don't want you there, but they have got problems of their own, you know, sometimes there's a lot of conflict on the ward and students just literally get in the way I think when there's that sort of pressure.*

Initially one can read these passages as a statement about different placement areas offering students different kinds of support. It can be read as a resource issue as well as about varying commitments, attitudes and work pressures. Linking these with statements made earlier by staff, they point to and reinforce some real worries that should concern policy makers who must make decisions about resource allocation and human resource management. There is also another level of analysis.

In curricular terms there is material here to promote reflective, critical exploration of the delivery of care within the real context of practice. Students are in a position to compare and contrast their experiences of different placement areas, exploring the social/cultural, political, and economic contexts in terms of their impact upon particular clinical settings and the delivery of care to particular clients. In their analyses they would be able to draw upon and thereby synthesise the knowledge bases, tools and techniques provided by the contributory disciplines of a given course (See Chapter 13).

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[1] It would be right also, it could be argued, to raise questions concerning the quality of care when it does not sufficiently resource reflective practice as a condition for mutual education in the clinical area.

There is a danger in demanding the ideal without regard to actual conditions. It is that it is so unobtainable that what can actually be achieved is not properly developed:

> *...unless every staff nurse in the country is (...) totally committed to education, knows all about teaching methods, is totally up to date on their practice, is a hundred and one percent research based, I mean it will never be ideal (....) I don't think that's something we can really aim for in the realistic world. We've just got to aim for as good as we can get.*

Aiming for 'as good as we can get' perhaps betrays a note of resignation that actually misses the educational challenge. That such an ideal is out of reach does not mean that the educational process will falter. Rather, the educational process only works if it is founded upon critical reflection on the given, real circumstances of practice. The student is a critical member of this process of reflection not as its passive object, but as its motivating agent. This is a point well understood in the latest ENB guidelines on assessment, in particular its criteria regarding the learning portfolio (ENB 1995 p 5.9 in ENB 1993-1995).

None of this should be read to imply that somehow resource shortages can be overcome if only people are ingenious enough to organise students to handle their own education. There are real and crucial limits. The effects of the 'hard decisions' being made day by day may either be immediately destructive of an educative environment, or may cumulatively build towards a crisis that is only noticed when something goes dramatically wrong.

7.4 Facing up to expectations

For both clinical staff and students, facing up to what each expects of the other is demanding. However, this is a central feature of any learning environment. It is a dimension of the more general process through which clients, staff and students are all engaged in 'facing up' to the expectation each have of the other.

Given the multiplicities of pressures, the presence of students in clinical working environments is typically perceived as demanding for staff. Students are required to have supervision, support, mentoring, teaching and both formative and summative assessment, appropriate to their level of ability and skill. Fulfilling these demands is exacting and facilitating students on undergraduate programmes may well be experienced and perceived as creating an extra demand for clinical staff. This may be thought of as stimulating and challenging, or anxiety provoking and threatening according to individual levels of personal and professional competence and confidence:

> *...there is a bit of concern (... from practitioners) you know, "We have only just got used to diploma students and now you are sending us degree students."*
> Lecturer

> *…a lot of people felt very fearful, and they didn't look so laterally at the needs, also felt very threatened and frightened.*
> Charge nurse

> *To me it doesn't seem to make much difference between post reg students, pre-reg diploma or degree students; they are just individuals who have their own needs, ideas, beliefs and attitudes.*
> Midwife

Students of course present their views from the other side of this relationship. They report that some misconceptions are eventually dispelled:

> *I think as you come out, as you leave wards and places, they sort of say, "We really, really liked working with you." And there's even… I was working in one hospital and they apologised when I left, they said, "I don't know if you realised, but we really didn't want you to come here," because it was a hospital that we don't normally go to, and she apologised afterwards.*

They also tell howon other occasions they have to work hard to break down barriers:

> *There has been a real stigma about us as we entered the wards, it was really difficult to like overcome, which has been, well I don't know, upsetting, but like annoying really. People have these ideas before they even meet you. They know that they are not going to like working with you…*

Midwifery students can face a double hurdle to acceptance when the relatively recent innovation of pre-registration midwifery is combined with undergraduate level programmes:

> *We had to prove ourselves from day one, and to justify ourselves from day one. (…) There was a lot of angst as to … umm the midwives around here couldn't get their heads around the idea that we weren't nurses first and that, umm how on earth did we think we could do it, and it was entirely necessary to have been a nurse first.*

Fitting in with staff in ward or community teams and being accepted and liked can thus become an issue for undergraduates who feel, or are made to feel 'different' to other students. Undergraduates feel they have to earn acceptance, often by deliberate communication of actions and attitudes:

> *…I think basically you've got to muck in and do…you've got to do the grotty jobs as well as, you know, the interesting stuff which I don't mind, I quite enjoy. (…) You've just go to muck in I think (pause) it's easier for them to accept you. I think if you are quite aloof then they don't get on with you as well.*
> Student

> *…they're very aware of the fact that they've got to create credibility and they've got to make the staff like them and show themselves to be proper nurses, so they bend*

> *over backwards and bust their guts, you know. They do offer to do the worst jobs, stay on late, above and beyond the call of duty.*
> Lecturer

However, since they are students, they must strike a delicate balance between demonstrating a willingness to do the "grotty jobs" and "muck in," whilst also stressing their educational needs:

> *Well, personally I had a hard time in the clinical area sort of justifying why I was doing a degree. And that yes, I was supernumerary, but that didn't mean I was going to stand in the corner, and that I was prepared to chip in and learn and work at the same time. And very often if other staff on the ward saw a tutor from the university coming on and dragging us off for two hours to reflect on what we were doing, (laughs) then they really resented that. And it caused an atmosphere on the wards sometimes I think.*

Facing up to expectations is clearly not easy. It means in a sense 'paying one's dues' by 'mucking in'. All social groups require the observation of certain rules and the carrying out of certain actions before acceptance is achieved. This should not be confused with educational processes. Being accepted in an occupational group may well be at odds with the innovative intentions of the educational process. There is typically a tension between socialisation and education in a learning organisation.

7.5 Sequencing clinical experience for learning

Reflection, to put it simplisticly, requires something to reflect upon and something to reflect with. Typically these two dimensions of the reflective act are thought of as reflection upon practice with the aid of theory. That this apparent separation may lead to a real separation has been discussed at several points in the report. Since 'theory' tends to be located within the physical spaces provided by the university, whereas practice takes place often many miles away in a clinical area the separation does indeed feel real. Hence, organising the periods in each of the locations is an act that has important curricular and learning implications. More than this, both going into practice and returning from practice are cultural, professional and emotional experiences which impact upon the identity of the individual. Students' initial encounters with the realities of practice can be alternately shocking, distressing, harrowing, satisfying and rewarding:

> *I remember we had a lady on the ward who had (…) a laparotomy, and she also had a new stoma, and her wound had dehisced and it was just an absolutely huge gaping wound really and I hadn't a clue really what to do about it, but I mean I was the one who was left to sort of, you know, clean it up and everything. (…) I mean the wound itself was just so horrendous you were dead scared just by the look of it when you've never seen anything like that before. It was just horrendous.*
>
> *Our first placement was at the end of the first term of the second year (…) I mean it seems like a short placement, it was four weeks (laughs) but to us it seemed like an absolute lifetime. (…) And this was (…) first experience, real experience of ward*

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> *life, and I think being a small group you're sort of dotted around here, there and everywhere so we weren't seeing each other (…) we were into our placements, we had four weeks, no contact, no … you know, it just seemed as if we were …totally isolated. And I think it was just a terrible shock for some people, you know not seeing their friends, not seeing their lecturers.*

Although not all undergraduates reported negative initial experiences, these accounts are reminders of the importance of preparation and support prior to their first encounters of practice, followed by debriefing of their experiences.

Most courses provide an introduction to care in community, hospital or occupational health settings during core or common foundation programmes, and early contact is welcomed by students:

> *…it's nice to go into it, you know, sort of from the beginning.*

> *…you need to 'cos I think when you're learning all the stuff in the university you need to go to the hospital and put it into practice.*

Students who have to wait until later in their course to get a taste of practice are less enthusiastic about this alternative approach. Front loading of theory with little experience of practice can be frustrating and, in the students' view, hinders integration of theory and practice:

> *We were desperate to get on the wards I think.*

> *Well the first year, I think the bad thing about this course is that the first year, it's all theory, you don't get any chance on the wards, you get a couple of observation visits in the first term .(…) I mean like for me, I don't know whether nursing is really what I want to do and so if I got to the second year and decided I don't really enjoy this it is a whole one year wasted.*

> *I would have preferred to have more clinical in the first 18 months. It was quite hard to focus on midwifery and relate any theory to it without the experience. Also midwifery theory done in the first 18 months was difficult to relate over a year later. It was like starting again.*

The issue of how best to structure practice and theory based activities throughout the course so that students gain a sense of integration and experience a holistic learning environment remains a challenging one. As previously argued, there is no simple timetabling solution. The point is reiterated in staff reflections upon the two most common general approaches; a combination of theory and practice within each week, or separate blocks of theory and practice:

> *…the argument for doing a couple of days each week in the clinical areas is precisely this trying to link the theory with the practice bit, that what you learn in theory you're at the same time practising, and that's meant to make it easier to link and all that…in the first two terms they usually do that – a certain number of days in*

> *practice. (…) In the extended summer term they go on block placements basically and I think most of the other courses are like that. Another side of the argument about not having block placements, is that when you work on the wards all the time and do shifts you get very locked into getting the work done (…) and not have the possibility to stand back and think about what you're doing because you just get bogged down in it so much.*
> Lecturer

> *...one thing that I always have a problem with (...with the) new course, is the problem of having just odd days as clinical placements. This is something that when I was a student I found very frustrating, and now this is what's happening with the students that are coming to us. They're coming for two days and from what I can gather from the student that is with me, in his perception of the three days (...) in the university, that it's not particularly integrated with the practice, so the things that they're doing don't necessarily need to be done at the same time as the practical stuff. I know the philosophy of the course is to integrate theory and practice where, wherever possible, and I think particularly in a speciality like psychiatry, a block of four or five weeks and the to go on and do the lecturers afterwards might be more useful. And I think the student that's on the ward currently feels that as well because he comes in, sees someone admitted and then of course a week later he comes back and he's missed out a huge chunk of their care completely, they're very, very different, and he's missed out on what's been happening and the continuity of care is completely lost. And we are a small ward so it's not so bad continuity of staff-wise, but certainly there is a problem in that he misses out big chunks of, and also the building relationships with, with*

It could be argued that these extracts suggest that some combination of both approaches might be the most beneficial way to maximise continuity of care and integration of learning and reflection without causing undue stress and upheaval for students. More fundamentally, it could be argued that the essential challenge is to generate the culture appropriate to creating the learning environment discussed in Chapter 5. This, it might further be argued is only possible if occupational cultures are themselves transformed into learning cultures which transcend both education and clinical settings (See Section 9: Chapter 14). In the meantime, a considerable weight falls upon the student to negotiate their own clinical experiences.

7.6 Negotiating clinical learning experiences

The majority of undergraduate students are supernumerary to staff duty rotas in clinical settings throughout their course[2]. Undergraduates are expected to gain realistic experiences of practice and hence they adopt staff working patterns of individual placements; for example shift systems which operate in the majority of hospital wards/units, and the more '9 to 5' routines of community care and hospital clinics, with

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[2] Undergraduates on courses do provide a service contribution similar to that of Dip HE Project 2000 students, ie 1000 hours usually towards the end of their course. However they have supernumerary status throughout the remainder of their course.

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'on call' duty as necessary. Such experiences reflect the nature of nursing and midwifery as activities which care for people for 24 hours each day of the year.

Arrangements must be made with clinical staff for undergraduates to achieve statutory requirements for clinical time whilst fully considering their learning needs:

> *...they negotiate their hours. That's something we've learnt from Project 2000. Project 2000, the idea when that was set up was that they would work 20 hours in practice, 9 to 3, and it doesn't work. The staff don't like it, the students don't like it (...) they miss the hand over time, they're not there for the whole shift, they don't know what's going on.*
> Lecturer

> *We should be doing a realistic off duty pattern, so yes, we should be working weekends, but no more than any staff nurse would be expected to work. So we wouldn't be expected to work every other week end (...) it should be as realistic as possible.*
> Student

Working with clinical staff is important to facilitate continuity of learning, support and assessment, although staff and students acknowledge that this may not be possible every shift. Minimum guidelines are set for many courses and the ENB now require students to work a minimum period equivalent to two working days per week with their assessor (ENB 1995 p 5.15 in ENB 1993-1995). The timing of clinical experience must enable observation of, or participation in, as full a range of clinical and educational activities as the clinical area (and any associated services) has to offer; for example working on a particular day of the week may enable a student to a visit to a specialist clinic or witness a clinical procedure in another department.

An educational focus is inherent in definitions of supernumerary status, however interpretations of the term in practice are variable. Misconceptions regarding the nature of supernumerary status were reported. One lecturer commented on the prevailing view of clinical staff in one unit:

> *("Students) are supernumerary therefore they don't do anything," and "It's a shame that they are supernumerary as they miss out on so much, because the only way that they are going to learn is by providing care." And so you can't get (across) the concept of what supernumerary means. You know, supernumerary doesn't mean you stand back and watch! (laughter) And it doesn't matter how many times you tell them, there is still this concept that we have not been able to sell.*
> Lecturer

As students have historically formed part of the NHS workforce, breaking away from the notion of students as workers can be difficult, especially when staff shortages coincide with increasing clinical workloads. In such circumstances, the primacy of student as learner, not worker needs to be positively endorsed.

However, inconsistency in the application of supernumerary status was reported by many students who felt pressured not to exercise their educational status. In such situations students felt their learning needs were secondary to the staffing needs of clinical areas:

> *Some wards are really good, some wards that we have been on say, "Fill in your own off duty." And then other wards have like put it down, and strictly you can not change it unless you put in a request first, which is a bit unfair when you are supernumerary anyway.*
> Student

> *People just didn't have a clue what it (being supernumerary) meant. And in some areas I think they actually took advantage of, they did know and they took advantage of you being there, and other times they just hadn't got a clue and you could sort of say what it was time and time again…*
> Graduate

> *...quite often they're not (treated as supernumerray), basically, and well sometimes they are and sometimes they're not, like today, one of the degree students has, has done me a favour because somebody's off sick and she's swapped another shift, and she is the third member of the, of the ward team, and she seems quite keen on this idea and that she would be allocated under the supervision of a staff nurse who would be allocated a group of patients and would work with them. But others, yesterday there were, she was extra to numbers, she was the extra nurse, but nonetheless she was still allocated to a group of patients along with the supervision, but it means that she was able to go off the ward, follow her patients through if they were going off the ward to occupational therapy. More freedom to be sort of involved in other things that are happening.*
> Ward Manager

Some undergraduates express strongly a view that abuse of their supernumerary status is unfair when students on diploma level midwifery and nursing courses receive more generous non means-tested NHS bursaries which take into account their rostered contributions to practice. Some students unsuccessfully raised this issue with lecturers (see section 10.1.7 in Chapter 10).

Students and lecturers give complex accounts of their decisions and actions taken when supernumerary status, and hence students' learning, are overlooked or disregarded in specific instances. When undergraduates felt staff were 'taking advantage' of them, tackling this situation was often personally threatening; undergraduates challenged or ignored individual situations according to their feelings of confidence, empowerment and the anticipated outcomes:

> *Well you could say, "Look here I'm supernumerary and will leave the ward if I wish," but where would that get you, you know?*

> *I think the year before us used their status a lot more than we had, we don't tend to use ours at all. I mean if we get booked in for weekends on our off duty, we just work the weekends, even though you're not meant to.*

Lecturers and students cited instances where abuse of supernumerary status provides opportunities for learning and reflection, rather than prompting confrontation and direct action:

> *…we were educated to be reflective practitioners, and so that even if we went on the ward where perhaps the nursing profession wasn't as appreciated (…) we could reflect on that critically, evaluate what was happening in that given situation.*
> Graduate

> *In a way I'm not unhappy about having been on a ward like that because (…) you can really sort of analyse what was going on there but wasn't very satisfactory, and perhaps compare it with the next surgical ward you go on, like in the third year, and see what was going on (…) what sort of changes you as a nurse could make.*
> Student

> *…when there is a lapse, which normally comes to light in a reflective session, we always try and approach it in a very positive manner. So certainly in their branch my first question to them is always, "Now imagine that you are the senior staff nurse on the ward at the time and how would you handle sorting out the ward for the day when you've got 26 patients and two students?" And I try to get them to see that there are no easy answers, and to look at what could be done, and I think on the whole they find that quite valuable. So certainly they are not looking to blame people when staffing levels are poor. And it does tend to be odd days, I can't think of any situation where they have had a really bad month on a ward.*
> Lecturer

Other undergraduates counted on support and direct action from education staff to endorse their learning agenda:

> *…we were supernumerary (…) we could perhaps utilise our time more effectively, in terms of, if we were counted in ward numbers and we were just being used on the ward (…) we could come and tell our department and they would sort it out for us to make sure that our time on the wards was used effectively.*
> Graduate

> *The nursing department say that you shouldn't feel, you know, worried about it, you should say if you need to go to the library, you should feel that you can ask if you want to say go and see an x-ray or go around with the physiotherapist, that you should feel confident to ask.*
> Student

On other courses, and in different circumstances, lecturers report feeling less empowered to act effectively. The level and quality of communication between lecturers and clinical staff, and the commitment to undergraduate learning in practice areas may be less than ideal due to other workplace pressures:

> *Students come back and tell me how many staff are on a particular shift and I feel that they have not considered my student to be supernumerary. And that is a very difficult area, they know perfectly well the student is supernumerary but there is nothing one can do about it once it's happened as it were. So again it's really not something that I can do much about at my level. The Head of Department meets with the managers and the purchasing consortium and reiterates our concerns.*

> *...a lot has to be done by good will. So when there is a situation where one is unhappy, one does have to be very careful about how it is handled. So for instance this situation where this student was left with ten patients to look after, I mean it's no good going in with guns blazing and saying, "this must never happen again. This is unsatisfactory." That really doesn't help. It's better to go in sort of say, "I was a bit worried about what this student has told me. And then of course they give you all these reasons for it and you are really are forced to say "Oh yes I quite understand."*

> *I think (clinical staff) are quite happy to have the undergraduates, as long as it does not cause them any grief. That's the sort of general feeling I get. I don't know, it's hard to say really. I mean I don't think that threatening to withdraw the students would be a (pause) I don't think they'd be heartbroken particularly. I don't know. It's hard to say whether they see it as being something good or something that they will just sort of go along with.*

7.7 The nature and quality of learning and assessment

This section considers experiences of assessing and facilitating student learning in the clinical environment with respect to establishing a) relationships to facilitate learning, b) providing support from educational staff, and c) facilitating continuous assessment of clinical practice.

7.7.1 Creating relationships to facilitate learning

One or more members of staff is formally allocated to each student with the objective of facilitating the clinical learning experience.

There is a need to maintain continuity of support provided by mentors and assessors[3], and formal systems of allocation are susceptible to disruption due to annual leave, sickness, night duty, periods of professional development or wards closures.

> *...it's a very informal process to be honest, I have reservations about the whole system really, (...) the way it works at the moment. It's very informal and we just*

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[3] See Section 7.6 of this chapter for the ENB's updated guidance, which had not been widely adopted during the period of the evaluation.

> *seem to jog along. There is not a structure to it, (students) are allocated a mentor and you kind of get on and work together if the mentor is on duty.*
> Practitioner

Contingency plans are required for continued student support. Where formal mentoring relationships do not work for practical reasons (or less frequently, because of personality clashes), some students seek alternative members of staff to those allocated.

Students reported experiences of variable quality of mentoring. They had clear ideas about the essential requirements of the role, citing commitment to student learning (in terms of time and enthusiasm), the ability to teach and facilitate up-to-date practice, an enlightened approach to care, and the capacity to interrelate theory and practice:

> *I would say 90% of the time it was very good. I don't know if that was by an accident or if they were chosen because they were quite forward thinking and liked the idea of degrees et cetera. And a lot of them helped me a lot with clinical issues in clinical practice. A couple of them didn't.*

> *...people were so generous with their time and explanations. (...) now I know when you're really rushed and you've got somebody asking you why you are doing something and all you want to do is get on to do the next thing and you haven't got time. And they took time, they put themselves behind and they went to a lot of trouble to collect information for us and they put on little talks and everything, everywhere we went to (...) it was excellent.*

> *...in some of my placements there wasn't such forward thinking (...in) other places you felt that the skills you had were welcomed and, you know, they encouraged you to contribute what you had learnt in terms of care planning and whatever, you know, nutritional scales. Whatever it was they encouraged it. Other areas weren't so encouraging.*

Practitioners' comments echo student experiences:

> *(You) need to like doing it, enjoy seeing people grow, develop, not to do it all yourself... the ability to delegate, to be approachable, to like talking. I think it is more than just being a friend, but some people take it on, "Oh let's like each other and become friends," rather than pushing professional development. (...) I do enjoy it, you could say that I think I have gained an awful lot and we have worked with some excellent students.*

> *...I think it depends on how the individual applies (...theory to practice) their own personal psychology, life experiences, you can talk academia all you like, but unless they are prepared to apply that and see it with their own eyes, what they have learnt and what they see it's not going to make any difference.*

Securing adequate support for student learning can be difficult, then, in working environments where clinical staff are pressured. The challenge is to promote real and

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realistic opportunities for learning in these circumstances (See Chapter 14: Principles 2.1 & 2.3)

7.7.2 Support from education staff

The role of a midwifery or nursing lecturer includes contact with clinical practice in a variety of forms. Most commonly, lecturers have clinical links with practice areas, which require contact on a regular basis. The ACE project (Bedford et al 1993) provided evidence of the difficulty of meeting the then ENB requirements. It is thus welcome that at the time of writing these are being reviewed and has become an ENB research priority (ENB 1995c).

For the purposes of this report, however, data refers to the period of the project which again reveals the considerable number of clinical areas that staff need to retain a reasonable level of contact with:

> *I think on paper it's a day a week, but it can't happen. It'd ...be very nice if it could. There's very little space in our working week, either teaching, meetings, marking, all the other things you do (...) It's made worse now because people working here may ...there are people working here who've got a clinical link with somewhere 30 miles away now because of the amalgamations that have gone on.*
>
> *Some of the teachers can manage their diary better than I can. One teacher accumulates and then has a week in practice, excellent. Sometimes I just run past the ward and wave and I think, "That's my clinical links for this week," it's desperate the pressures. But the college policy is half a day a week and we have to fulfil that, but we are moving to one day a week in clinical practice, which is good.*

Actively prioritising clinical time so that it is on an equal footing with teaching or attending meetings is one strategy adopted by staff to ensure that it does not become marginal:

> *I have done what Stella has done and planned in my diary a day per week in the clinical area (...) when something happened I'd cancel that. I won't budge now because that time is so easily eaten into and I now turn around to someone and say, "I am in the clinical areas," and I have no problem with that and if other people have a problem with it, then tough, it will have to wait like any other meeting.*

The nature of the clinical role is frequently defined by educational policies and is subject to interpretations by individuals. Lecturers on one programme work with students in the clinical areas and participate in their clinical assessment, whilst others stress the importance of developmental work with clinical staff or maintaining lecturers' clinical skills:

> *I think we've abandoned the idea of clinical teaching...and seen the main role as developing the trained staff to present the right sort of environment for the students.*

> *I see them (lecturing staff) supporting students and staff. (…) one lecturer is setting up action learning groups for staff in one hospital (…) I'm giving them flexibility, but I also do expect them to do some clinical work too (…) for their own professional credibility*
> Senior Lecturer

Other means of instilling a positive academic influence in the clinical areas are via joint appointments and lecturer practitioner roles. Joint appointments are usually held between HE institutions and clinical units. The role is usually divided between lecturing activities and supporting the clinical environment via teaching, development and in some instances, the delivery of care. More unusually, lecturers at one university have half time commitments to research in clinical areas.

Joint appointments can be stressful as staff endeavour to meet the demands of both roles, particularly if integration between the two halves is limited:

> *…the health service doesn't really seem to be able to cope very well with the idea of a joint appointment being one job and having spin offs for both sides, as well as negative aspects of it. So it's seen very much as having two half time posts really.*

The role of the lecturer practitioner is a more recent innovation, perceived by many lecturers as a positive way of integrating the spheres of practice and theory. In contrast with the role of a joint appointment, staff are able to make the role more their own. As one lecturer practitioner explains:

> *As far as the role is concerned, I think you'll probably find that most LP's would say the same, is that it's not what it might appear at first view to be a sort of joint appointment between two departments. It's much more complex than that and at times the clinical side of the job, the educational side appear to be two distinct entities, and at other times it's impossible to say what you're doing at any one time. I thought I would have certain days when I would be educational, certain days when I would be clinical – that doesn't really happen, apart from occasionally if (…) I'm practising on the ward (…) then I could say, yes, I'm purely clinical, but then students pop down so that becomes partly educational.*

Whilst lecturers acknowledged the difficulties of sustaining regular links with clinical areas, they recognise the need to keep apace of the clinical change and be sensitive to its effects on individuals:

> *…while we are beavering away designing new programmes, things are changing out there. For instance in midwifery, teams, case loads and so on. And they are going through such radical upheaval and we are sending them students with totally new philosophies and so on. I mean they are very stressful, and I mean they are still trying to come to grips with levels and different assessment and all sorts of things, but I think they are managing that well.*

Regular contact with the undergraduates is hoped to stimulate understanding, with knock on effects of commitment and enthusiasm:

> *We're also trying – and obviously we don't know how this is going to work, you have to try these things out and see what happens – to use the same wards on a regular basis. (…) every year we'll use the same ward for the same unit of learning so that the staff in those areas will get to know what the needs and requirements of the undergraduates are.*

Although undergraduates have highly individual needs for support which vary throughout their course, a general observation can be made regarding the need for accessible support and effective debriefing of experience[4]. Support from lecturing staff is particularly important within a context where support from clinical staff can no longer be guaranteed:

> *…there are not enough mentors to go around that have done a teaching and assessing course (…) So in that sense the fewer qualified nurses on the wards means the fewer nurses that are available. And the mentors that are available have to be shared more thinly. Now that is something in a way that we don't really have a great deal of control over because the funding to do more people doing the 998 is beyond our control. So that is a problem, especially as we are coming under pressure to reduce our hours, our clinical hours, so I have students out on the wards and I'm, when I first came here we were allocated three hours per student, per visit and we saw each student twice (…) on a placement for five weeks (…) Now that has been cut to two and a half, and it will be cut again, and at some point it ceases to be a useful exercise.*
> Lecturer

Comments from undergraduates reflect the varied levels of support which lecturing staff provide:

> *I think definitely in your first year you feel you need a lot more support. You probably get more in your first year if you remember back. We got two or three when we were on one ward. But by the time you get into the third year you sort your problems out yourself with the other staff, well that is the way I would prefer to do it rather than people from the college coming in and sorting out your problems for you. I would hate that!*
>
> *Because I'm one of the student reps (…) I always ask people what they want us to say when I go to the meetings and they always say, "We want the clinical links to come out more, and they tend to come out in the last week." (…The lecturers) always say, "Ring us if you've got a problem."*

7.7.3 Continuous assessment of clinical practice

The dialogue, questioning and reflection integral to learning relationships between students and clinical facilitators are intended to form the basis of continuous assessment. Such formative activity should support and inform summative decision making regarding student progress in achieving predetermined standards at junctures throughout the course.

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[4] See Chapter 8 for accounts of reflection on practice facilitated by lecturing staff.

Methods and tools for formative and summative assessments of practice range from documents to plan and validate student achievement by box ticking and supplying supportive comments, to more descriptive and reflective journals, dairies or log books, and finally to reflective, negotiated and evidence based formats such as learning contracts.

New guidelines (ENB 1995 section 5 in ENB 1993-1995) which must be enacted by December 1997 require institutional assessment strategies which ensure that, "equal value and accreditation is given to assessment of both theory and practice." At present only a minority of undergraduate programmes accredit practice.

There are acknowledged difficulties of meeting the aspirations to accredit practice satisfactorily at the present time. Some undergraduate programmes aim for this in the future, but have to live with compromise:

> *...we include the practice element in their final award in that the link between theory and practice is so evident, but we are aware that what we would like to do is include the (clinical) supervisors (...) more in the actual awarding of the degree by assessing the practice competence. But we don't want to do that...we are fearful of doing that until we have developed some more sophisticated method is assessing competency. We are alright with the behavioural ones, we have got two forms of assessment; one is the behavioural outcomes (... and) we have got the process ones where the students discuss things and it takes a degree of sophistication and knowledge of the course. (...) What we will find I think is that at the moment the supervisors in clinical practice will say, "Yes, they have got 90%, they are so wonderful." So it will be an over assessment rather than I think under assessment.*

Examples of credit rated practice at other institutions can be found:

> *...a care study applied to an individual client that they've nursed, backed up by, you know, extensive literature and research based referencing for their interventions and their care planning and et cetera, their evaluations and a teaching of health promotional type activity, you know, have clearly integrated themes which have been apparent from year one, and developed during year two, which are about, sort of communication with a client, about promoting health, and have made them actually look in a very concrete was at umm, delivering the goods rather than just having it as a rhetoric.*

There were initial plans that a clinical practitioner would be involved in marking, but difficulties were experienced:

> *I think the intention originally was to, and rightly so, was to have this triad approach. Umm, the difficulty has been in practice with the first cohort that not all credit rated supervisors felt competent academically...to make that judgement. So we ended up double marking with the university but with a copy of the document, I*

> *mean obviously as supervisors they are working closely with the student in the production of the this from the earliest stages and planning it and in the operationalising of it. But we have asked them to really write is a comment which reflects on the accuracy, the validity umm and the, how realistic the proposals are in respect of care that's going on. So we, although it's not a formal mark it's certainly a very important criterion that's used both in-house and by the externals to determine whether the grade that we're proposing is actually relevant or not or whether in fact the piece of work is fictitious or is, is really anchored in reality. And that has been really useful. It's been a halfway point and I think we'd really like to move onto the point where we can ask the clinical supervisors to first or second mark that piece of work.*

A culture of shared understandings as to the purpose and process of practice based assessment by students and clinical facilitators is vital.

The needs for continuity, commitment, skill, understanding and dialogue spoken of earlier in connection with relationships for learning are just as pertinent to the assessment process. Exploring potential causes for the variance of these qualities leads to the identification of familiar patterns of inadequate resourcing of clinical learning (See Chapter 8). Pressures on clinical staff frequently appear to thwart motivation and commitments to student learning.

The data highlights the need for continued development of valid approaches to assessment through piloting, dialogue and evaluation. It emphasises the need to make continued attempts to create greater shared understanding of and knowledge about the assessment process. Where lack of assessor understanding persists, the process of assessment can be reduced to the uncritical and possibly erroneous completion of documentation:

> *Actually a lot of the time mentors didn't really seem to understand some of the competencies but signed them anyway because they had to and because the university said they had to. (...) "I don't know what the hell this means but I'll sign it anyway because you've been a good worker," nod nod, wink wink, you know. So I'm sure I'm not the only one that's happened to.*
> Graduate

This disturbing account reiterates several messages, namely the need for students to be empowered and take responsibility for their own learning, development and standards of practice; the need for accurate, regular and effective communication with, and monitoring quality of the clinical learning area; and also the need to ensure the commitment and responsibility of clinical staff charged with facilitating student learning and providing assessment proof of the students level of achievement.

The professional development needs of clinical staff are clear.

7.8 Summary

Meeting the aims and aspirations of undergraduate learning in present day clinical contexts poses considerable challenges. Students are required to be mentored and assessed to become safe, competent practitioners, able to integrate and interrogate theory. Analytical and reflective practice should be consistently developed during experiences in a variety of clinical placements, and there is a need to ensure progression and continuity of learning between experiences.

This considerable task is achieved within demanding, busy programmes where space for reflection is often limited. There is little opportunity to revisit clinical experiences, and students must make the most of every placement to ensure that their developmental needs are met and accurately and constructively assessed at each planned stage.

The data reveals that significant variation in the quality of support, teaching, facilitation and assessment is a common experience for undergraduates. This can be attributed to a range of causes, including contexts of change in clinical areas, the quality of initial preparation for mentoring and assessing roles, quality of ongoing education, communication and liaison between clinical facilitators and HE staff, quality and effectiveness of mechanisms for evaluating clinical learning and assessing, reliability and validity of assessment methods and their use in action.

It is evident that undergraduates can experience an unpredictable, and at times unacceptable, range of quality, because of insufficient resourcing. A common theme running through the above points and the summary of the previous, related chapter is that sufficient and appropriate resources of time, staffing and professional development, together with commitment, communication, negotiation and shared ownership are required to optimise undergraduate clinical learning experiences. Adoption of the ENB's revised regulations and guidance relating to assessment (ENB 1995 section 5 in ENB 1993-1995) will meet these needs. It is anticipated that ensuring the availability of resources and effective strategies for lecturers to fulfil their requirements for 0.2 WTE in the clinical area will greatly increase the quality of dialogue with students, mentors and assessors, will enable any problems to be detected and addressed early, and will act as ongoing evaluation in addition to annual educational audit. ENB commissioning of research (ENB 1995c) into effective strategies and models to enable lecturers to fulfil clinical aspects of their roles is welcomed.

CHAPTER EIGHT

Experiences of learning in Higher Education

Introduction

The learning environment has as its aim the subjective organisation of the student's and the professional's experience in ways which contribute to dialogue and the sharing of understandings (See Chapter 14: Principles 4.1 & 5.2).

Experiences of learning will be considered in the chapter as follows:

- Aims of student learning;
- Strategies for teaching and learning:
    - lecturer lead/facilitate,
    - self directed.
    - reflection;
- Assessment.

8.1 Aims of student learning

The aims expressed in curriculum documentation have to be interpreted in practice. Lecturers are mediators of this process. Their grasp and commitment to these aims is thus important. As may be expected, if staff have been closely involved in curriculum design, they are likely to have a grasp of its values and aims and have in mind an image of the kind of student that they expect to develop:

> *Somebody who can be analytical, someone who can problem solve, somebody who will be flexible. Somebody who can think rather than just do things from rote. And the students find that very difficult, and some of the students don't like that, they want to know what the answer is to things, you know. As a team we believe that that's not the appropriate way to kind of turn out graduate nurses. I don't have the answers they want, I want them to find their own answers. Now that's uncomfortable for them, it's uncomfortable for us as teachers as well because it's easier to give the answers according to me....I have my answers but I want them to develop their own. So I think we have that kind of philosophy. (...The students) are dealing with their own kind of growth and uncertainty and that's the nature of being an undergraduate.*

> *You are teaching graduates on a graduate programme to look and be critical about lots of different things, (...) to read in a critical sense... it's going to be important to*

> *them to be aware that they can do it themselves, they can pursue avenues of practice of theory and link the two things together.*

The task is to provide the intellectual, cultural and social conditions for students to develop in two ways: first as professionals and secondly at 'degree' level. Thus, distinctions are often made between practitioners educated to graduate level as opposed to diploma level:

> *...the quality in terms safe practice is the same, what makes the difference is I think within the culture of the way in which individuals are taught and the way in which they are attempting to make them think. It's a question of them being perhaps led in a way that makes them critical, more questioning, more aware of current literature and issues and more able to debate.*

Detailed specifications of the differences were, however, very difficult to find. This is an issue that will be taken up again in Chapter 14. In general, meeting these broad aspirations requires appropriately reflective, critical and questioning approaches to teaching, learning and assessment. Due to the highly condensed nature of courses with 40 or more weeks in each academic year, it could be argued that to meet these aims, structures and climates which foster active learning must be introduced, developed and consistently applied during courses from an early stage. But, as is well known, what a teacher intends and what actually occurs need not necessarily coincide.

8.2 Strategies for teaching and learning

A variety of approaches to teaching and learning are employed on undergraduate courses and students experience a mixture of:

- lecturer lead/facilitated teaching and learning;
- self directed learning;
- reflection.

8.2.1 Lecturer lead or facilitated teaching and learning

Data about lecturer-lead teaching and learning provides evidence about a) the major approaches adopted to sequence the foundations of learning, b) the formats employed for teaching and learning, c) the implications of various teaching formats for relevance and for resources, d) the quality of lecturing, and e) the nature, quality and extent of academic support.

- **Approaches to sequencing the foundations of learning**

The intention for any learning environment is that it will have some impact on the subjective organisation of experience. The curricular intention is to design a framework within which this will occur together with the means to assess the extent to which it has occurred successfully. Teaching, as the agency through which experiences are engineered, reflected upon and in some way integrated within the individual, can adopt a number of possible approaches to achieve this. These include:

-transmission teaching , where the teacher is the supposed repository of 'knowledge' which then is transmitted to students, rather like a flow of water from a reservoir down a pipe to fill a bucket. Assessment attends to the extent to which the student is able to reproduce the 'knowledge' so transmitted.

-discovery teaching , where the teacher suppresses his or her 'knowledge' in the belief that the student will learn best through reflecting upon experience and so 'discovering' for his or herself. To do this the teacher retains a covert map of the learning that needs to be covered and manipulates the environment (both the material and symbolic environment) in order to engineer experiences of discovery. Assessment attends to the extent that the student has 'discovered' and can comprehend what he or she is supposed to discover.

-dialogic teaching, where the teacher suppresses his or her supposed 'expertise' and power, with the intention of identifying i) the learning needs of students as defined by the students in relation to ii) a dialogue with others who are significant to the community within which the students work, play and act. Assessment attends to the extent to which students are able to reflect upon experience, formulate action plans in negotiation with others and implement these.

The locus of power subtly shifts in the move from the first, through the second to the third model of the teaching process.

Faced with the new experiences on offer to them in HE or in clinical areas, students need to develop a repertoire of theories and approaches to learning which enable them to make sense of these experiences, and to develop, challenge and reconstruct their knowledge base. At the start of courses, lecture formats are frequently used to deliver the foundations from which students can begin to progress:

> *It's been very basic, I mean they actually started off with umm, you know, the building blocks, perspectives the psychologists use.*
>
> *I think they are trying to give us background at the moment, everything we learn later they're gonna pull on what they're given us and then they're likely to top it, so it's like a taster at the moment.*

At the beginning, students' immediate needs include an understanding of the often perplexing terminology used in nursing and midwifery:

> *Well what they eventually did was give us a crash course in jargon didn't they, gave us lists (...) and told us to buy a midwifery dictionary and to carry on reading and if we got stuck, go and have a look in the dictionary. And it actually worked quite well.*

Lecturing inputs onto the programmes are typically provided by a range of subject specialists, and students report variable consistency between approaches and styles which then they experience as aiding or blocking initial learning. Here a student compares her experiences of nursing and midwifery lectures:

> *...they start off with no assumptions about what you know, they go in at the bottom and work their way up for you, whereas the (non midwifery/nursing) lecturers seem to go in somewhere up here, assume a knowledge that perhaps you haven't got and go on from there so you are left with this enormous gap here that you are trying to madly fill.*

The contrast here is between a transmission model of learning which makes no allowance for where the student is starting from and what might be called a construction model of learning which starts from the student and builds upon what the student 'knows'. The former is a mass model of learning leading no doubt to 'economies of scale, the latter a 'custom built' model which tailors courses to individual needs and is thus expensive in terms of staff numbers, time and energy.

Without knowing more about the values of the particular courses and the teachers involved, both models are consistent with a view of a curriculum that seeks 'coverage' of a supposed basic content. It can only be maintained if the assumption is that coverage of content is a prime requirement of undergraduate courses. Given current exponential rates of increase in information and scientific knowledge, coverage of all there is to know is an absurdity. The cultural shift[1] implicit in the notion of the reflective practitioner and the research based professional is that coverage is not prime but the ability to inquire, and learn independently is. The implications for designing learning environments are substantial.

- **Formats for teaching and learning: the role of relevance and content**

Students comment on their need to make the theory live in relation to practice. Mass transmission forms of teaching directed towards a general audience rarely facilitate this. The alternative is to encourage students to bring clinical experience into learning situations.

The perceived benefits for staff and students of participatory and challenging approaches such as seminars that actively involve students, genuinely collaborative team teaching, and shared learning events where careful planning has occurred, are perceived to be of great benefit. However, they require appropriate resources of time and professional development (See Chapter 5).

If sharing is to be effective and not just a cost saving exercise it requires careful planning, delivery and evaluation. Typically, shared learning begins with a perceived commonality (perhaps at a generic level) or complementarity in content or in process:

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[1] Chapter 12 discusses issues of graduates in practice, and assumptions and expectations of graduates practitioners as representing 'new kinds' of practitioners are explored in section 12.4 of the chapter.

> *Where we have service teaching will vary, in social policy they will gear it very much towards what they think the students need to know as nursing practitioners and particularly going into the community and I think that's relatively easy (...) because it's the shared force of social work students and I think social work students are the nearest comparator for our students. (...) Nursing is more like social work than it is like medicine say. With the medics the element of application doesn't seem to be there (...) the first two or three years it's pre-clinical, it's nothing to do with clinical, it's just labs.*
> Lecturer

Just where the boundaries are drawn between 'fields' perceived as 'nearest comparators' and those seen as too different is something that will vary according to the views of the speaker and the emphasis and discipline strengths of the degree. In the following data extract, the lecturer employs a different criterion for inclusion (clinical practice) and hence draws the boundary differently:

> *...they have shared learning in practice, so what is the difference with theory? (...) I think the midwifery and nursing professions to some extent have got to look at what other professions do, the value of shared learning. (...) There are so many disciplines we can share with, OT, physio, medical students.*

- **Quality of lecturing**

At a resource level, for quality to be safeguarded, a relatively stable staffing complement is needed to offer some continuity to the learning process(see section 5.4 of Chapter 5):

> *We had lots of changes of staff, and the module team leader left and no one had any idea what she had done.*

> *...staff were coming and going and there wasn't much continuity there. I mean, I think for one theme in the course we had maybe five, six lecturers in the course of 18 months and they kept changing so there would be no consistency there at all.*

However undergraduates on the majority of programmes report what they considered to be a high standard of lecturing and teaching. They judge this standard in relation to a) how well the lecturers engage tstudents in learning, b) how effective they are at questioning and encouraging students to ask questions, and c) how well they bring theory and practice together.

Attempts by lecturers to encourage active involvement are welcomed by students. Their views on passive forms of learning speak for themselves:

> *...a person from the physiology department comes in and gives a lecture. We write it down – the notes – and go home and put them in a file.*

> *...the anatomy wasn't too bad because you can learn that parrot fashion to the point where, just so long as you can get the names in your head, but the physiology was very tough, it was ridiculous. The very first lecture I could have sat there and cried.*
>
> *...we don't usually know the name of the person unless we've got a list.*

There was enthusiasm for lecturers who facilitated questions and discussion within teaching sessions:

> *...they're very open to questions as well, I mean they don't mind at all if somebody stops and says, "Hang on, what do you mean by that?"*

However, when lecturers exhibit a lack of confidence or ability when handling questions, students feel their own learning is impeded, and a sense of conflict is created:

> *...it created quite a lot of conflict I think right the way through the course because we all, we all wanted to learn it, and you just asked quite innocent questions that you wanted more information on and I think it caused quite a lot of conflict really.*

The integration of theory generated through study and practice are essential to the development of a sound midwifery or nursing knowledge base. The professional nurse or midwife lecturer plays a key role in this process.

> *...my role is to try and incorporate academic into the clinical context and to me the whole basis is about being able to do it, so it doesn't matter how good you are your ideas are or how relevant or current your theory is if you can't put it in to practice it looses reality really.*
> Lecturer

As may be expected, students want someone who can help them integrate theory with practice, to enable them to understand and to see relevance and implement it in practical situations. This may be perceived as a process of information transference:

> *I mean their skill is in transferring, the teacher I would say has the skill of transferring their information to you, for you to understand.*
> Student

Or it may be perceived as someone having clinical credibility:

> *...quite often they got people from the hospital to come out and teach us and that was absolutely brilliant, because it was people who really knew their stuff.*

Student comments reiterate the need for staffing resources (on quantitative and qualitative fronts), as well as resources and structures, which are sufficient to facilitate the demands of establishing a new degree programme.

- **Academic support**

In addition to more formal teaching situations, students require academic support on an individual basis. Lecturer commitment to support for student learning is evident throughout the data, however the quantity and quality of support received is influenced by role pressures and accessibility of staff (See also Chapter 11):

> *...the lecturers do say, "now if you're having problems, my room in such and such, come along and I'll try and help you."*
>
> *And also it comes down even (to) just personal interests, you know, like your dissertation, that's a personal interest as well as a sort of professional (one). And they're all for that as well, they're all for you achieving those sort of personal aims as well as your professional, which is good because to keep the motivation and the enthusiasm is really...they really recognise that here. They really do.*
>
> *And I can only say that I tried very hard on several occasions to arrange to have tutorials that never came off, or you know they would be five minutes here or there. And in the end I'm afraid you know, after a few times of trying I gave up and thought, "Well I'm better doing it on my own."*
>
> *My tutor for my dissertation just lives fairly near, like five minutes away from where I live. I was like going up on a Saturday or going over on a Sunday (...) popping over to show her my work and the rest of it. And I mean I know that's not standard, what normally happens, but the fact that people are willing to do that is amazing really.*

8.2.2 Self directed learning

In addition to contact with lecturers, students have timetabled hours for self directed study. It seems that early facilitation is essential. Without resources for student assistance and support, students feel less able to make effective use of opportunities for learning:

> *And they kept coming up with this guff about being an adult learner, but never treated you as one (...) they never, ever explained what they expected a self directed learner was. (...) I mean we did theories of learning in the third year right at the end, and suddenly you were doing your androgogical studies and you think, "Oh that's why!" And if they give you, umm free self directed study at the start when you don't really know what you are aiming to self direct to study, then it is wasted time. There is no direction there.*
>
> *Towards the end of the course it became us giving more seminars and things But again I think they tried to promote us teaching ourselves, experiential learning, but I think it wasn't backed up by a really good grounding from them, so it was ...what little we learnt we just had to go and try and learn as much as we could by ourselves.*

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However, when students *are* facilitated with skills and resources to carry out effective self directed learning, their time is used effectively and the experience is rewarding:

> *In the first year I found it quite difficult because a lot of it, I suppose because of the lack of time, a lot of gaining knowledge which is self directed, you know we'd have a sort of seminar type thing, we'd get a huge long reading list and told to go away and go to the library and read about whatever subject it was. And I found that quite difficult in the first year, having come from a traditional 'A' level course where you're more or less spoon fed notes on physics or whatever. But then I got used to it and after a while I started to thrive in it really, and I found it very enjoyable to go to the library and do my own stuff and form my own opinions about subjects and be able to write critical projects and essays about issues.*

Self-directed learning is clearly a worthwhile activity if it is properly set up and mainained. However, because of the costs involved in ensuring a quality experience, it is not - and cannot be - a cheap option.

8.2.3 Reflection

The role of reflective activities has been shown to be central to the values of professional midwifery and nursing practice. It is expressed as a principle in Chapter 14, principle 7.1. How it is actively and effectively structured and facilitated within undergraduate programmes is particularly important within pressurised, high content courses where competition between activities are high. An additional consideration is the development of lecturers' own reflective abilities.

Where reflection is regularly structured throughout the course and students' reflective abilities are nurtured, the activity is perceived as challenging and beneficial to both staff and students:

> *And that has been very interesting because in the first year they are always, (...) "We want the answers. This is what happened, show me the answers." And there is a shift in the second year to the kind of thing, "Well I remembered what had happened before," and even people, actually in the critical incidents will refer to a theory, will say, "Although I thought about so and so, I thought this was relevant. (...)" So they will use formal and informal theories, their own personal experience (...) which is really exciting, you know, because they are seeing it and watching it develop.*
> Lecturer

> *...we try and link their own experience, (...) "Can we explain it in terms of our own experience or can we explain it in terms of formal theory or what?" Often you can't, you know, there isn't any. But it's surprising what comes out. (...) You can get at students assumptions, you can realise how you are teaching and how your teaching is falling short of what you intended it to be.*
> Lecturer

Journals and critical incidents play an important role in helping to develop integration of learning experiences.

> *My belief in reflection comes from the activities of reflection that is journal keeping. Because I think it is intensely personally valuable (...) and I think on an individual basis I think people can grow through that medium.*
>
> *Initially (we assist students in) writing critically about interpersonal skills which they've been involved with themselves in their placements, so when they come back next term they can start reflecting on those things that are in the diary, write it up as good or bad interpersonal skills, and take that on and develop their diaries. (…) I mean they started in dribs and drabs, didn't push them too hard, gave them ideas in how to overcome blocks in starting writing, things like that. And they're all keeping them now. So it took two terms for them to actually get into writing them and see the benefit of them, but that's what I expected.*
>
> *The students are expected to bring in excerpt from their journals and they are all suppose to learn how to analyse one another's presentations. Some things they bring to these groups would make you weep, they're heart breaking (...) because the student just like the traditional student know these things shouldn't happen, or they learn from things that have happened that are appropriate. I'm not saying they reflect automatically , they're doing it because they have to do it for the module and the journal.*
> Lecturer
>
> *Using critical incidents often reveals issues wider that the original one. For discussion of this type and depth to occur the content of the curriculum has to be effectively planned and time tabled, and issues identified as to what needs teaching and what can be learnt by the student independently.*
> Lecturer

Where students and graduates report poorly facilitated activities they do not appear to be educationally reflective:

> *…it wasn't very well structured. (…) And I think because we were all such a close group we really did a lot more of it informally ourselves because we were nattering about what we were doing. But just again, it would have been nice to have more…I don't know, more informed structure.*
> Student
>
> Student: *…you would have quite a few like brainstorming sessions where you would be saying, they would say, "What have you seen this week?" (…) we used to enjoy that (…) learning from each other's experiences, basically we would say what we had seen and what had been done about it.*
>
> Researcher: *So would it be quite descriptive?*
>
> Student: *Very.*

> Researcher: *And in terms of thinking about things like reflective practice, have you heard of Schon's work, where they talk about reflection in and reflection on practice?*
>
> Student: *No. (…) There wasn't much input from the tutors, it would just be us discussing what we had seen and done. Umm, they were quite a useful stress reliever in a way.*

Another group comments:

> Student 1: *We've never had meetings to discuss our experiences on the ward have we?*
>
> Student 2: *No*
>
> Student 1: *I don't think – or just have moaning sessions about wards, it's always between your own group that you go around with.*
>
> Researcher: *So there's no debriefing of that experience?*
>
> Students 1& 2: *No*
>
> Student 3: *People at home or your friends, they always get it.*

Where students are offered an opportunity to share both positive and negative experiences, this can reduce stress generated by situations which they either do not fully understand or for which they have received inadequate support.

Ideally reflection would occur between triads of students, practitioners and lecturers as an integral activity throughout the courses. This involving of clinical staff in joint reflective activities to develop sharing and dialogue appears to be problematic because of the role pressures, time constraints. and the cost of replacement clinical staff. Here a lecturer outlines difficulties encountered on one course where planned sessions to discuss work based clinical logs have been abandoned:

> *I mean to be absolutely honest we've given up asking (the clinical staff). I took that out of the new cohort's book because no one ever came and I didn't feel that it was fair to have it in the book when it didn't happen. (…) I mean they just don't have the time (…) but the students do discuss their clinical logs with clinical staff, and in some areas the clinical staff are very keen on helping them.*

A possible alternative solution to this would be for nurse and midwife teachers to use some of the clinical link roles to operate reflective sessions in the clinical area.

8.3 Assessment

Assessment was a prime focus of the ACE Report (Bedford, Phillips, Robinson, Schostak 1993). Changes in ENB policy regarding assessment occurred late in the life of the TYDE project (ENB 1995 section 5 in ENB 1993 – 1995) and hence have not significantly impacted upon the undergraduate courses. Issues similar to those raised in the ACE Report are relevant also for TYDE. The following provides only a summary of approaches and some key perceptions relating assessment with reflective practice.

Continuous assessment of theory varies significantly from course to course in terms of its quantity and nature. Undergraduates are required to complete a variety of formative and summative assessment activities, designed to demonstrate academic progression and increasing integration with nursing or midwifery practice.

Typical examples of formative assessment activities include essays, health education care plans, negotiated seminars, research critiques, learning journals, peer-assessed critical incident discussion, presentations of research papers, case study presentations, self evaluations, student/teacher interviews reflecting on progress, and target setting. While typical summative activities include unseen exams, seen exams, negotiated exams (negotiated 6 weeks prior to exam), multiple choice questions, and research based dissertations (15,000 words).

The number of summative assessment activities which students are required to complete varies considerably from course to course; for example 9, 22, and 23 summative assessments on three year courses, and 20, 28 and 44 on four year programmes. Consequently over-assessment is a concern, as its domination within tightly packed courses defines and constricts learning, and can create immense pressure on students:

The weaknesses, I think we over assess our students incredibly. My first degree was an academic degree (...) and I can never remember studying the way our students study. What they do, they have a very instrumental approach to the course so it is very... they see, they go from assignment to assignment, so that's what they are doing all the time, they are forever writing essays to be assessed rather than writing for development, reading for development, reading because this is interesting rather than, "I need to read this for my essay."

> *I learnt it parrot fashion so I didn't learn anything really. I picked out three subjects, wrote them out, and parrot and remembered them So they were essays basically, but they expected us to get good marks for them.*
> Student

> *(It) feels at times like an uphill battle because like so many students, they get uptight about the assessment strategy that you feel like you're battering your head (...when they say) "What you say is not important because that might not come into the exam and we need to know these facts."*
> Lecturer

The process of developing effective assessment strategies takes time, and adjustments following initial experiences have been reported frequently. This may involve fine tuning or radical alteration of the strategy. Examples from the data include reducing the number of assessments or altering the balance, timing and interrelation of formative and summative activities. Here a lecturer describes changes to the programme to ensure successful integration of theory and practice from an early stage in the course:

> *...we were expecting people to go in the second year having done mainly formative assessments in the first year. (...) We have found that we are picking up (...) a problem of applying theory to practice, so we are trying to do it very gently with all*

> *the different disciplines, so we are getting them to explore the disciplines and then very gently try to sort of think of ways in which they can apply it to practice. But their practice is very limited. But nevertheless we are doing that from the very beginning, but doing it more systematically…*
> Lecturer

The quantity of assessments undertaken is not as important as its quality. The ACE Report argued that assessment is part of the process of constructing a learning environment appropriate to the values and intentions of the curriculum for professional practice. It should at least provide the means by which to provide the evidence base upon which judgements about the fitness of an individual to be a professional can be taken. This evidence base could perhaps be developed and assessed in relationship to the principle concerning 'consequential judgement' in Chapter 14, Section 7.4.

8.4 Summary

Principles 1.1, 4.1; 5.2; 7.1 and 8.2 in Chapter 14 have particular relevance for this chapter. As this chapter (and indeed this report in totality) reiterates, the aims of undergraduate learning are ambitious and demanding to realise and deliver, particularly within highly pressurised academic years.

A variety of strategies are used to develop student learning and assessment, both lecturer facilitated and student self directed. The extent of innovatory approaches adopted varies according to curriculum planning, institutional/professional philosophies, expertise and availability of resources.

The delivery of some stated course aims and intentions appears to be problematic. Undergraduates report most variation in the extent and quality of reflective activities, where a lack of structured activity coupled with weak introductory foundations and little timetabled opportunity for students to develop their skills, mitigates against meeting intended learning outcomes.

Within high content programmes operating over extended academic years, be they three or four years in length, the planning and delivery of course aims requires imagination and careful structuring, backed up by resources to ensure effective implementation.

Over-assessment which leads to domination of learning and increased student and staff pressure is reported to be a problem on some programmes. As more undergraduate courses adopt modular structures, greater attention will need to be paid to the volume and nature of assessment in order that undergraduates' learning is not restricted by assessment-led curricula.

CHAPTER NINE

Monitoring the degree programmes

Introduction

The earlier chapters have discussed the intellectual, practical and material problems that have to be addressed in order to deliver a high quality degree level professional education. The difficulty to be explored in this chapter is in identifying ways of defining quality. A single definition that covers all possible categories of problem is not possible because all institutions differ significantly in their historical and contemporary circumstances, there are competing discourses through which concepts concerning quality are constructed, and because there is no stable enduring end point where change and development stops. Education is fundamentally about transitions and transformations that by their very nature do not culminate in a fixed and enduring point of development. If there were such 'end points', it may be that the cluster of problems which together define the problem structure of any institution may be reduced to a relatively unproblematic set. Such a set could serve many different personal, professional, managerial and political vested interests. Currently, for example, government has produced criteria that can be used to create league tables to assess the performance of schools, universities and hospitals. These are highly controversial yet can powerfully determine the allocation of resources between institutions and departments within institutions. If the criteria inadequately represent or indeed are woefully misleading, then clearly resources will not be allocated appropriately according to the real problems to be addressed. Such crude measures are too easily stripped of the contextual insights required to make sophisticated judgements about relative quality.

This project does not intend to present any definitive list of criteria but rather to formulate principles and possible procedures in the context of discussion. Specific criteria can only emerge if embedded in detailed and continuous institutional dialogue and debate. This project does not wish to usurp that process but rather to contribute to it. To this end this chapter will focus upon four approaches to monitoring:

- crude measures;
- formal monitoring and quality assurance;
- seeking "voices";
- formative and dialogic structures and processes.

It is hoped that by setting these four approaches into relationship, some underlying guiding principles can be discerned. It will be argued that formative and dialogic approaches can be employed to structure and embed the multiplicities of voices (students, lecturers, clinicians, managers and so on), formal monitoring systems and the crude measures of course outcomes.

9.1 Crude measures

What makes a particular measure crude is not the mere fact that it is a quantity. What makes a particular measure crude is when it glosses over complexity in order to achieve simple categories that can be measured. In Needham's (1983) terms crudity can be defined as the process of replacing polythetic forms of categorisation by monothetic forms so that statistical procedures can be applied. It can further be argued that the level of complexity of insitutions and social practices - the sheer number of possible variables to take into account together with their dynamic unstable nature - renders any controlled measurement for comparative purposes absurd. It is crude in a further sense when measures are demanded because they are associated with the social authority of such sciences as physics. This is a political ploy not a scientific strategy. Science resides in the use of methods appropriate to the field of study, that is, methods capable of representing the 'realities' about which they speak. Methods appropriate to the physical world are not necessarily appropriate to the symbolic worlds of human values, judgements, decisions and actions.

Crude measures may be undertaken at various points during or at the end of courses, for example assessed performance in practice, summative assessments, attrition rates, pass rates and degree classification, and employment following graduation. Such information, by itself is not particularly informative. Even making the information less crude by taking into account entry qualifications, age, experience and relevant social and personal factors says little about the quality of the educational process and the levels of professional judgement and abilities of the graduate. Indeed during the data collection period of the project most institutions, although assessing clinical practice, did not accredit it in terms of degree classification. This will change. New ENB regulations and guidance note that by December 1997 institutional assessment strategies must ensure that "equal value and accreditation is given to assessment of both theory and practice." (ENB 1995 p 5.5 in ENB 1993-1995).

The task is to seek forms that can adequately encompass the transition from student to practitioner. For some this is experienced as a plateau period before a sense of development occurs; for others the learning is continuous. In either case, crude measures do not pick up these kinds of transitions as purposeful developments with their own logic. Practice areas can be organised to support purposeful developments. So, where the practice area functions as an effective learning environment for all staff the 'plateau' may be short, with new practitioners being facilitated by more experienced practitioners in meeting identified learning needs. However where the values and practices of the clinical area are incongruent with the students prior learning, experience and/or philosophy it may take longer. In such circumstances the graduate has to learn to handle the situation in such a way that they can either act as a change agent, 'survive' or negotiate their own space for personal and professional action and development. These two circumstacnes require quite different qualities from the student. To be 'competent' in the one is not necessarily to be competent in the other. To employ crude measures of performance would do an injustice to both. The evidence base to inform judgement about the students will be quite different in each case. Quality procedures need to be sensitive to the different possible cases that may arise. Indeed, they need to be able to address what may be called judgements, decisions and actions of real consequence in practice (See Chapter 14: Principle 7.2).

In the light of the above arguments, the following sections will descibe and explore current practices in assuring and determining quality.

9.2 Formal monitoring and quality assurance

All organisations need some way of being able to sense external and internal changes, needs, problems and so on. Monitoring and quality assurance fulfil some part of this need. Ensuring that an organisation is sensitive to the internal and external conditions requires more than a passive self regulating mechanism like the feedback devices in a central heating system. Here a feedback arrangement can be set up which ensures that if the temperature falls below or rises above a certain point, the heating is switched on or off accordingly. Feedback for an organisation is as much to do with alerting the organisation to unexpected circumstances and to new definitions of what is possible, as it is about ensuring previously defined criteria are being met. This kind of sensitivity depends upon the quality of the information being brought into dialogue for debate as a basis to inform judgement and action.[1]

Formal mechanisms employed to accomplish quality assurance need to span course delivery in both education and clinical areas. These internal mechanisms include student evaluations, course management committees, assessment committees, academic boards, pathway management; while among the external mechanisms are external examiners, visits by ENB education officers and submission of annual reports, and HEFCE, HMI or OFSTED inspections.

The first category includes issues of transition:

> *The university has its own monitoring arrangements for all courses but these of course have changed because they were originally CNAA and now they are internal and I don't believe that the university understands the nursing programmes anyway. And of course during the transition period, monitoring has been extremely slack. That's not because it would normally be slack, that's just because of the transition.*

A second category of issues concerns quality assurance in clinical areas. This is made more complex due to the current purchaser provider arrangements. Course documentation typically makes reference to the monitoring of the practice areas:

> *As practice is an important aspect of the course it is particularly relevant to evaluate and closely monitor, throughout the course, outcomes of the practice modules.*

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[1] See Chapter 14, general principle of dialogue in section 6 with specific implications for integrating clinical practice section 10 with shared reflection 7.2, and 7.3 and the development of a research culture in section 9.

Unfortunately, often little more detail is provided about how this is actually done. Although it may be stated that clinical placements are monitored formally on an annual basis, with the change in relationship to a purchaser provider one, there is now a lack of leverage from education in relation to alterations in the clinical environment.

A third set of issues relate to the implications that follow from evaluations of a given module or of the course as a whole. For example, the timing of such evaluations are often seen as problematic:

> *... because it's at the end of the module it doesn't affect, it's too late.*

Summative evaluations of a course are important. However, because they occur at the end of a course or module students can feel that they are pointless for themselves but may at least have some effect for those who follow. If change still does not take place then students feel increasingly disempowered:

> *They asked us to evaluate things, which we evaluated time after time after time, but no measures seemed to be taken of those evaluations whatsoever.*
>
> *... the atmosphere was pretty bad at times because we got frustrated with it and I think that didn't help.*
>
> *... whenever we had the evaluations it was always very, very heated and (pause) I don't know, I might be, I might completely misjudge it but I think a lot of people were just glad to finish and move on.*

This extreme situation aside, it is clear that not all aspects of a given course are amenable to immediate change. For example some changes may be considered so large that they need to wait for revalidation; or simply impossible due to lack of resources or financing. In other cases, however, it is the sense of fighting 'the university':

> Student: *I think it's got to be said, the assessment system has been far from ideal, with long spells of quiet and then spells where (...we) had a lot of concentrated (assessment) and a lot of that's down to university policy which unfortunately...who actually dictate what percentage of our degree we can actually cover in each of the three years. And we actually want to get that changed in nursing because of the clinical practice pressures as well, but I don't know if that will ever happen.*
> Researcher: *(...) Have you sort of been able to take that to the course committee and say...*
> Student: *Yes, yes...*
> Researcher: *What's their response to that?*
> Student: *Their response is they don't think they can do anything about it, but it's been minuted and it's going to heads of department meetings (...) to see if anything can be done.(...) We're sort of fighting here against university policy, which is more difficult to fight against. Something may change; when I don't know.*

Many of these kinds of problem are less to do with immovable structures and more to do with the fact that many staff are on a learning curve, are experiencing turbulent times, working in the dark, and coping with staff shortages. Some of these problems can be considered temporary and many can be overcome during the process of learning from experience. In either case, their effects on all courses can be significant but with the intensive nature of programmes operating a 40-45 week year (whether these are three or four year format) the impact may be more profound. The more intensive the course, the more effective (that is, resulting in action) the quality assurance processes and procedures have to be.

The fourth category of issues concerns external monitoring. External examiners for nursing and midwifery courses have to be approved by the ENB and are charged with reviewing both the academic and the practice elements of the course.

Securing experienced and academically credible external examiners for nursing and midwifery degrees programme emerges as a problematic area for some relatively immature programmes. Increased needs for external examiners on undergraduate programmes are occurring at a time of rapid academic development amongst nursing and midwifery lecturers. In the extract below, a lecturer from an allied discipline involved in facilitating development of a new nursing and midwifery degree comments on how experiences in nursing and midwifery do not yet match up with general university practice for the appointment of external assessors:

> *...if I mainly talk for example about the criteria for appointing an external examiner (..). Clearly within the university the expectation is that, I mean in my department it's virtually only professors who would be externals to my department. We have two externals both are professors at established universities. (..). They would expect there to be a CV which had at least a dozen publications on it, of which at least one or two should be books, and research background which has indicated the ability to attract thousands, (..) ten to twenty thousands perhaps.*

Detailed external monitoring of a course as a whole seems problematic for some courses:

> *In terms of monitoring, the short and honest answer is that nobody has monitored. The ENB comes once a year, it can see in a few hours what it wants to see, or what people choose to show it. It has never had the chance to overlook the whole programme at all.*

It could be argued that to expect such comprehensive monitoring is unrealistic. A full evaluation of a given course would require very considerable resources. However, what may be more realistic is a form of monitoring which looks at the ways an institution and/or department makes itself sensitive to the contexts and processes of course operation. This kind of sensitivity comes with ensuring full involvement in course debate and management, by representatives from teaching staff, clinical areas and each year cohort of the course.

9.3 Voices

There is no single interpretation for any given text or experience. Different people tend to give different accounts of situations. Without dialogue being structured into learning experiences, these differences of interpretation can too easily overlooked (See Chapter 14: Principles 6.1 & 6.2). Thus for example:

> *... at the end of each term we have an evaluation which we always open up to all staff who have mentored, plus ward sisters and managers. Now we might sometimes get two, which even though if you only have two, they often make such a valuable contribution to the discussion of the evaluation, because we find now that evaluations now have got to have a little bit more substance than they used to have in that they won't just be general gripes, they will be looking beyond (that). If something has gone wrong, well why has it gone wrong? It is the nature of the changes going on in the health services anyway? For instance we had one evaluation where the student said, you know seminars are all very well when you are presenting the material, but when it is somebody else you don't learn as much from it. And it was interesting that because the two health service staff nurse there said, "Oh I wish we'd had seminars because of how articulate you are! We found it extremely difficult when we became staff nurses because we weren't used to speaking to a lot of people." And you know, students thought about it and said, "Yes we take some things for granted don't we?" So they are able...if we had said it, it wouldn't have held any water for them really, but because these staff nurses said it they really took it on board and thought, "Oh well maybe there is something in this." And in fact the next evaluation we had after they had done seminar work they said, "Oh there is more to be gained, we realise that."*

During an evaluation, by ensuring representation from all viewpoints, both staff and students can begin to address the problem structure of learning and of teaching both in the education and clinical practice areas. Students, by listening to the voices of the staff nurses, are able to re-assess their previous judgements concerning the course. This implies that quality assurance can bring a change in awareness that is educative. It can only do that, however, if voices are adequately represented in an exchange of views. Unfortunately, attendance at evaluation events by representatives of clinical staff is often made difficult, or even impossible, because of pressures of time, travel expenses and the cost of replacing them in the clinical area.

How information is gathered matters. The nature of the method affects the quality of the information. The usual methods of generating information from students include questionnaires which may be qualitative or quantitative in nature, nominal group technique, discussion groups, and evaluation of the clinical learning environment. Those for clinical staff include profile assessment, discussion, liaison via the link tutor and questionnaires. How these individual methods are structured into the course also matters. Each strategy can contribute to the sense of one's voice being important. By exploring interviews it is possible to discern some underlying principles. When the principles are in operation students as well as staff feel empowered to improve the quality of teaching and learning. For example these students comment upon their feelings of being able to effect change:

> *I think one of the things we've become much better at (is) noticing the areas that we need more teaching in or whatever. And I think both on placement and in the university we are well encouraged and well able to voice those needs. That's one of the things that (…) the nursing staff I have been working with have said, that we are much more able to put across what we need and get from them. And I think a lot of the staff really, really like that, they like the fact that it seems a much more even relationship with us.*

Many examples of the importance of feeling empowered can be found:

> *…at the end of every module, because the course is still quite new, they have a module evaluation which we do and we fill out the forms (…) confidentially. And we can put any comment we like on they are read by the lecturer and clinical staff leading that module and they do take note (…) of what we say, and have changed modules in the past for the year below, so yes they really do count on what we, what our comments are.*

Good feedback in these ways have meant that some places have radically altered their assessment systems after an initial run through or have made smaller improvements which nevertheless impact strongly on the quality of the course:

> *I think it tends to be small sort of time-table changes, negotiating extra study time. It's things like that on the whole, if we want changed and we say why we want it changed, which they have been fairly amenable to…*
>
> *We had a bit of a problem with biochemistry, but that got sorted out because the lecturer pitched it above the heads of most of people so…with negotiation, I think it was low.*

The small size of courses means that relationships can be closer and that teachers can respond flexibly and speedily:

> *But the small group that we have got, the cohesiveness of the team has meant that the team attends seminars (…) so that means you can alter your teaching, or monitoring what kind of teaching goes on, so the course does change a lot really…*

Two principles emerge. There is a need for a) relationships at a personal level which encourage sensitivity and speed of communication, and b) a clear link between feedback and action.

A further example of where the system of student evaluation worked to good effect was when students felt concern about the rushed delivery of lectures by a relatively inexperienced lecturer. Students' requests for the lecturer to slow down and repeat areas which they were finding difficult to follow failed, and hence non attendance at lectures was becoming a problem. This issue was resolved by a more experienced member of staff whose role it was to meet course representatives on a regular basis. During face to face discussions withthe senior colleague, the lecturer reassurance was given concerning his control of the curriculum content and suggestions were provided about alternative styles of delivery. This process was described by the experienced member of staff in the following way:

> *I say let's maintain student contact, lets nip problems in the bud, eliminate the need for having very difficult meetings which are not very constructive in moving forward.*

There are two dimensions here. The first is to do with maintaining a continuous level of contact with students in such a way that problems can be identified quickly, and secondly, to deal with the problems at an early stage in ways that do not invoke formal or bureaucratic mechanisms. It is a matter of defusing problems before they get too big. In management terms:

> *I am aware of what's going on, I know the students personally, once they come in I know what their name is, I know where they come from, what dissertations (they are) doing and I get that through feedback through each year tutor collectively. (…) And that is again an internal way for me to hear about how the course is being delivered, where there are problems and to ensure that quality is maintained. I'm using quality in the broadest sense in terms of student satisfaction, staff's own views of how it can be catered for.*
> Course Leader

This responsiveness to changing need is important at all stages of course maturation but perhaps particularly important when a course is running for the first time. New courses create new challenges, take time to settle down, iron out problems, establish good communication channels, work through problems and so on. Some students felt they benefited from being part of a pioneer group despite any hiccups:

> *…we were the guinea pigs, they were just testing things out to see what worked and what didn't work (…) they were very flexible with us you know.*
> Graduate

Whilst students on another course perceived problems that were not just due to its newness:

> *I think we have to appreciate of course that we were the first lot through and we were the guinea pigs, but we had that excuse thrown at us so many times, the mismanagement and the misorganisation (…) it made everything have a level of stress much higher than it needed to have…*

Similarly, being the pioneers of a newly revised course:

> *…we were the first year of the re-written lot. I think that it was assumed that there were a lot of problems previously, and the assumption was that they'd put all the problems right, and so now the course was going to be just right. And of course, I mean we had lots of problems that the other people didn't have, but were caused by changing it and they didn't seem to recognise that.*
> Graduate

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Being on an old course that is running out also has evaluation implications, as students can feel marginalised:

> *We're often told, "Oh this is changing, don't worry about it, it's all changing now." This is no good to you when you're fed up with something or you suggest about something.*
>
> *...we have been pushed from pillar to post really, and umm, as a set really I think that's fairly disheartened (...) the whole place...*

When dissatisfaction occurs, it is important to have a system sufficiently sensitive to alert staff. Informal mechanisms which do not link with the more formal leave individuals with a sense of disempowerment and a lack of ownership of the course. This appears to be particularly the case for clinical staff:

> *...as far as I know there is no set procedure, and really it is left a lot to the mentor to get in touch. It would be ideal to have more meetings so that there can be a two way exchange. The only real way to raise your concerns is to write it on the back of the student assessment form, because that is discussed with the student and goes back to the tutor as we don't see them in their link role enough; but on the delivery suite that is difficult as it can be busy and nobody has the time.*
> Practitioner

Good practice, then, requires face-to-face meetings on a regular basis:

> *Yeah we have reflections once a week with one of the learning difficulties tutors and you can bring up all sorts or, it's used for business...information which is relevant to the learning difficulties branch or general information, course information and then any problems , general problems as a group, and then lots of discussions. They are very good sessions because you can let off steam in a great way, it's always a good way for the tutors to find out what's happening with the students.*

Meetings, however, not only serve the function of 'letting off steam' but at their best can facilitate quality by ensuring sensitivity:

> *I try to ensure that quality is maintained year by year and if problems develop, for example I have meetings outside the Course Management Committee (CMC) with course representatives (...) each year has a representative, a student rep, so I would meet with them (...) to discuss issues which might come up that might be problematic and see if I can resolve that without taking it to CMC.*

9.4 Formative and dialogic structures and processes

To ensure that all voices are heard and empowered clearly demands considerable planning and resources. In effect, it would require a continuous process that was both dialogic in structure and formative in intent. The dialogic structure would bring together the voices and generate agendas from their concerns, interests, needs. This is an approach that is implicit in the model of professional education that is discussed and developed in outline form in Chapter 14. The desired outcome of such a process is that students are able to articulate their views:

> *I think both on placement and in the university we are all encouraged and well able to voice those needs. That's one of the things that (...) the nursing staff I have been working with have said, that we are much more able to put across what we need to get from them.*
> *(3rd year student)*

It is not an outcome that is readily quantifiable. It is a statement that becomes fully appreciated only when it is understood as being embedded in many contexts. At the personal level, it is embedded in the biographical context of the student, thus changes at the level of the self have taken place. At the interpersonal level there are the relationships between clinical area staff which have been developed and which may change due to the influence of the student/graduate. In addition there are the implicit comparisons that can be made with others who are not *'able to put across what (they) need to get from (staff).'* One implication at the personal and interpersonal levels is that such students are not so easily socialised into the clinical areas as in traditional forms of training. There is then a potential impact upon occupational culture that has effects in the long and very long terms as the careers of graduates develop over a lifetime. This in turn has implications for the nature, and practice and organisation of care in the long term.

The kinds of transitions spoken about by Schön (1983) and Benner (1984) take time. To facilitate such transitions a temporal logic of development has to be built into the structures and mechanisms through which a course is sustained and delivered. A three or a four year degree level course can only do so much. Our expectations need to be realistic. We need to explore what we mean by a professional education and how best to structure that course over time (see Chapter 13).

9.5 Summary

It is possible to identify some needs which recognise the embedded nature of teaching and learning, including a) the need to ensure organisational sensitivity to changing internal and external conditions, b) the need to ensure communication to all levels in the system and at all key stages in the process of education, c) the need to ensure the structuring of 'voices' to facilitate dialogue, and d) the need to ensure a clear link between dialogue, feedback and resultant action, development and learning.

What needs to be asked of any given organisational structure is, can a mechanism/ mechanisms be identified that fulfil the function of implementing a given principle? (See Chapter 14: Principles 2.3; 6.1 & 6.2).

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CHAPTER TEN

Student finances and part time work – some implications for learning

Introduction

This section outlines the personal funding arrangements for undergraduate midwives and nurses. It charts the recent transition from substantial central provision for students in HE towards increased individual responsibility for financial maintenance. It explores individual responses to these new demands, and the impact of financial status on students' learning agendas. In addition, it notes the distinctly different sources and levels of funding which currently exist for students on pre-registration nursing and midwifery courses at degree and diploma level. The critical question to be asked by educationalists is whether the financial burdens being placed upon students lead to unacceptable compromise of educational values. (See Chapter 14:Principle 2.1.)

10.1 Student finances

10.1.1 Funding for undergraduate students

As full-time students in higher education, undergraduate nurses and midwives are eligible to apply for a means tested Local Education Authority (LEA) grant to cover living costs. Individual awards are made on the basis of the maximum entitlement (i.e. the basic rate of grant plus any allowances which may be claimed) less contributions made by the student, their parent, parents or spouse (Department for Education 1995).

Levels of grant were frozen in 1990, and annual reductions of 10% of the grant level came into effect for the years 1994 and 1995 (see Table 10a below). A further decrease of 10% is planned for 1996. As a consequence there is increasing concern relating to student hardship, rising levels of debt and increasing reliance on part time work which may be to the detriment of study (Committee of Vice Chancellors and Principals of the Universities of the United Kingdom 1993; Committee of Vice Chancellors and Principals of the Universities of the United Kingdom 1994b; Times Higher Education Supplement 1994; Doughty & Homayounnejad 1994).

	Year of academic entry		
	1993	1994	1995
Living away from parental home			
- studying in London	£2,845	£2,560	£2,340
- studying elsewhere	£2,265	£2,040	£1,885
Living and studying at parental home	£1,795	£1,615	£1,530

Table 10a: Levels of Local Education Authority Grants for the Academic Years 1993-1996 (Source Department for Education 1993a; 1993b; 1995)

On courses requiring attendance in excess of the standard 30 weeks and 3 days (which include a significant number of the undergraduate programmes in nursing and midwifery), students can apply for an allowance for each additional week[1]. Students on courses requiring attendance for 45 or more weeks per 12 month period become eligible to apply for a means tested LEA grant covering a full 52 week period (Department for Education 1995: 29), hence midwives and nurses on the three year programmes are included in this category. Other additional allowances may be paid to students who have dependants (Department for Education 1995: 30).

Student loans are increasingly used as a source of funding by students in HE. The Student Loans Scheme was introduced in 1990 in the Education (Student Loans) Act, and students are eligible to apply for a loan if they are home students on full time courses (i.e. lasting at least one year) in HE . Student loans are non means tested, that is irrespective of any grants, awards, other income, income of parents, spouses, partners or other relatives, earlier loans (unless repayments are overdue) and financial record. Current levels of loans available to students are given in Table 10b. In recent years an increase in the maximum level of loan available to each student has been planned to compensate for reductions in levels of LEA grants (Department for Education 1995, p13).

	Year of academic entry		
	1993	1994	1995
Away from parental home			
– London	£940 (£685)	£1,375 (£1,005)	£1,695 (£1,240)
– Elsewhere	£800 (£585)	£1,150 (£850)	£1,385 (£1,010)
Living at parental home	£640 (£470)	£915 (£670)	£1065 (£780)

Table 10b: Maximum Student Loans for the Academic Years 1993 – 1995 (figures in brackets relate to students in their final year, as the sum does not cover a summer holiday period) (Source: Department for Education 1993a; 1993b; 1995)

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[1] Weekly rates are as follows: London rate - £75.90; 'Elsewhere' rate - £56.85; Parental home rate - £39.85 (Source Department for Education 1995 p 29).

Student loans must be repaid over a five year period under most circumstances, although early repayments are possible. Monthly payments are usually made, commencing in the April after a course finishes. Students are charged interest on their loan at an inflation linked rate, adjusted at yearly intervals in line with the Retail Prices Index. Students on incomes which are less than 85% of national average earnings are able defer their repayments. The current level of earnings below which payment of loans may be deferred (up to 31 July 1995) is a gross monthly income of less than £1,216, i.e. £14,592 per annum (Department for Education 1995, p 21). It is noteworthy that the usual current starting salaries[2] of staff nurses (grade D, i.e. £11,320) and midwives (grade E, i.e. £12,950) (See Chapter 12) do not reach the national average.

The Government also provides limited funds to HE institutions for financial assistance of students in cases of severe hardship, or for students who would otherwise be unable to support themselves through Higher Education (Department for Education 1995). Access Funds are non repayable. There is considerable competition and excess demand for these finite resources. Students in financial need may also be able to borrow Hardship Funds from their university or college. Such monies must be repaid before a student may graduate.

Undergraduate nurses and midwives can also face considerable extra costs specific to their chosen course of study. One of the more expensive aspects for students is travel to placement areas, which can be extensive when travel is required outside immediate localities. Car parking charges are also being introduced at a number of hospitals. Such travel costs are in addition to those incurred travelling between multiple sites and facilities of their universities or colleges. Students on nursing[3], medical or dentistry courses who must attend placements in the United Kingdom away from their main college of study may be eligible to apply for travelling expenses exceeding those allocated within any LEA grant (i.e. £237 for students on the 'at home' rate and £153 for students receiving the 'London' or 'elsewhere' rate) (Department for Education 1995: 29).

10.1.2 Funding for diploma students

In contrast to the majority of undergraduate students[4], students on Project 2000 or pre-registration midwifery courses at diploma level receive non means tested NHS bursaries (see Table 10c). Funding for these programmes originates from the NHS. Diplomate students are honorarily contracted to learn and practice in local Trusts, and unlike the majority of undergraduates who are supernumerary in clinical settings for the duration of their course, diploma students provide a 20% rostered service contribution, usually towards the end of their course.

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[2] These figures are correct at the time of writing and do not include outcomes of the 1995 pay award. Extra payments are made for midwives and nurses employed in the London area.

[3] There is no mention of midwifery students in DfE guidance, however it is assumed that the term 'nursing' is used generically to also include midwifery.

[4] Undergraduates on one midwifery course participating in the TYDE project are funded via NHS bursaries.

	Location of study	
	Provinces	London
Age at start of course		
under 26	£4,450	£5,230
26 or over	£5,010	£5,785

(Additional allowances are payable to students with dependants)

Table 10c: Current Levels of NHS Bursaries for Students on Diploma Level Project 2000 courses and Pre-Registration Midwifery Diplomas (Source: NHS Executive (1995) Executive Letter EL (95) 80, Student Bursaries (24.7.95) Leeds: NHS Executive)

In addition to NHS bursaries, students on diploma level courses are entitled to claim for reimbursement of travelling expenses to clinical sites. Many are also able to rent living accommodation at NHS sites at a subsidised rate. The costs of such accommodation are generally much lower than that available to undergraduate midwives and nurses in the university or private sector. However rising costs and the declining standard of some NHS accommodation has been the subject of criticism (Mangan 1993; Plant 1993; Tyler 1994).

10.1.3 Undergraduates' experiences of living on grants

All the students interviewed for the project received some form of financial assistance, the most substantial contribution being in the form of a full LEA grant, parental or spousal contributions or a mixture of both sources. Some undergraduates reported difficulties anticipating how much money they would have to live on and just how far this money would stretch:

> *...it was quite difficult trying to find out how much you get on the degree when you've got dependants and things like that. Until you'd applied you couldn't find out how much you'd get. So I mean you just sort of like presumed that you'd be about the same off, but you're not.*[5]

> *...and as far as the money aspect, it's probably going to sound pretty naive, but I came straight from home, I didn't have a clue how much things like food and stuff cost me because my parents had always paid for it, so I didn't really realise the financial things I don't think really.*

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[5] This student, a single parent, was experiencing severe financial problems and a recent application for £4,000 from university Access Funds yielded only £900. She was also doing more than 16 hours of part time work per week to remain solvent.

Ensuring receipt of full entitlement of an LEA grant was a protracted process for some undergraduates and their lecturers, especially when claiming allowances to cover extra weeks of study required for courses:

> *I think we had to write some letters and stuff to get the education authorities aware that we needed a 52 week grant. I mean even last year I didn't get the full 52 weeks because they claimed (…) I finished in June, but I finished in September.*
> Graduate

> *…the grant authorities can't get it into their minds that they do a 42 or whatever week year, you know they just can't understand. (…) And then you've got all these letters to write to grant authorities to say, "Yes, our students are really doing a 42 week year, because they're doing their placements as well as their academic subjects." (…) By the time that's processed through a county authority or whatever, they're often left without monies.*
> Lecturer

Many students are dependent on their parents or spouse for some or all of their costs of living. Some students were fortunate in that their parents or spouses could supplement their basic allowances, but others were not. Receiving financial support from parents or spouse was not always without stress, and some resented their feelings of dependency:

> *I knew it was going to be quite hard, but I didn't realise that you'd still be so dependent on your parents.*

> *You've got to have helpful parents. I've got a student loan so I suppose yes, I am in debt. Not as badly as I could be and not as bad as some students, but there's still a financial commitment there.*

> *…when I was awarded my grant, the nursery here made an assessment on what I should pay, but it wasn't specifically put onto my income of the grant, it was combined with my husbands wages and so actually most of my grant for about the first year and a half went towards nursery fees, it left…maybe £100 a term for me (…) on a rather major assumption that my husband wouldn't actually mind supporting me financially through the course with things like travelling costs, books pens, stationary, that sort of thing. (…) it's actually draining from the family budget for you to do the course…I mean it certainly was for me, I mean I've had to take out a student loan every year and that was really to have some kind of financial grant n order to buy books and other things and to put towards petrol costs and travelling expenses.*

10.1.4 Travelling expenses and safety issues

As noted previously, students on medically related courses who are in receipt of LEA grants are eligible to claim for travel expenses to clinical placements which exceed the amounts allotted within their grants. Of those students who are eligible and who do apply, some report that the process of applying for travelling expenses is not as equitable as it would appear, and that reimbursement from LEA's is not always guaranteed. Students told of the persistence and determination required to make a successful claim:

> *That can be humiliating as well if you've got to keep hassling, you're not doing it because you've been going out partying, you're doing it because you can't afford to get somewhere.*

On a small number of courses, there is faculty or departmental funding for travel to clinical placements. At one university a course leader secured reimbursement from the faculty for students' travelling costs after a lengthy period of negotiation. Unfortunately such financial assistance may be short lived as the overspent faculty has to review it's expenditure:

> *We could argue on moral grounds it could be wrong, but sooner or later moral grounds get pushed aside by the economic argument being considered, and I am afraid that if economically things don't improve we will loose it. Now I've fought for five years to get it and we've had the privilege of using it for two years and I could see it going down the pan. Now I think it would cause great hardship to students…*

Some students have cars as a necessity, and where possible travel-share arrangements reduce cost and inconvenience. This is not always possible if students working at the same placements have different shift patterns. Using public transport to get to and from placements at unsociable hours can be at best inconvenient, and at worst impossible and unsafe. Personal safety is a worrying issue for students, lecturers and parents as some placements are in city areas notorious for crime. Students often need to travel in the dark of early mornings, late evenings and nights because of shift patterns. Two incidents of a mugging and a near rape reported in the data highlight the real dangers that student nurses, midwives (and indeed other health professionals) face. As the following student's comments clearly indicate, being safe is expensive, and despite lobbying a range of potential sources of financial support for travel her efforts have so far been unsuccessful:

> *And also the travelling expenses has been the real big issue for us, you've got nowhere to claim from on the cost of bus fares etc., etc. and within that you also have the safety aspects of it that people, you know are having to sort of, if they can't afford the bus fare then they may have to walk and that may put them in jeopardy of a very dangerous area of this particular city. One of the hospitals, the main hospital is actually, you know right in the middle of the red light district where there is an awful high crime rate (…) and people are having to walk perhaps when they would catch a bus or maybe get a taxi if they felt really unsafe, but there's absolutely nowhere to claim expenses for that. So I mean we have actually been trying to negotiate (…) some kind of like minibus or expenses, but one or the other, something that highlights the safety aspects.*

10.1.5 Accommodation and additional course related costs

Undergraduates on some courses are guaranteed a place in HE owned accommodation for their first year, but this is not always the case. Those lucky enough to be offered a place can usually anticipate a reasonable standard of accommodation, whereas the quality of rented accommodation is not guaranteed (Stearn 1993). The costs of accommodation often amount to a large proportion of a student grant. Securing a contract for accommodation which suits the length of the academic year on a nursing or midwifery degree is not always easy, and some students report paying rent over holidays periods or double rent whilst on clinical placement. Some undergraduates were able to secure NHS accommodation on placements away from their educational base, but terms and conditions for this were not always on a par with those applying to NHS funded students. For example in one locality NHS funded diplomats were able to claim rent rebates during holiday periods when not using their rooms whereas undergraduate students were not.

Other costs associated with midwifery and nursing courses include purchasing uniforms (which are sometimes not always supplied to undergraduates by NHS Trusts or HE institutions, work shoes, hosiery, a fob watch and scissors. These items soon add up and lecturers are keen to ensure that prospective students are informed of these and additional placement related costs:

> *I always make sure before they come that they're aware, they get a written letter (…) before they come (…) they get a letter from me to say that they will need certain things. And instead of the sort of like, black shoes and all the rest of it that we used to send, we now say, "Well you will need for your placement at least £10 per day (…) to go there and back and food," and all the rest of it.*

Students on many courses have to fund the cost of producing a substantial research based dissertation in their final year, although a small number of departments do provide financial assistance for this purpose. Clinical electives, sometimes spent abroad, also form part of some degree programmes which students fund predominantly through sponsorship, fund-raising activities or self/parental financing. Electives abroad are sometimes arranged through the ERASMUS (European Community Action Scheme for the Mobility of University Students) scheme, and students are allocated grants from the ERASMUS Student Grant Council (EC 1994).

10.1.6 Financial pressures and debt

As the data from the TYDE project illustrate, current levels of grant provide an insufficient financial basis for day to day living for many nursing and midwifery undergraduates. Supplementing this income is often a worry for students, be it that they are required to request cash from parents or spouses, or take on part time work for extra money. The effect of such circumstances on learning agendas are not insignificant, and are recognised by staff and students:

> *I think it's true to say that there has been a lot of stress felt by everybody because we've had financial worries on top of work, especially with it being a three year course. I don't know whether you've found this anywhere else, but we only get seven weeks (holiday) a year) and we just get like £65 a week and it hardly covers rent, food, bills and if you' want anything else on top of that you've got to work.*

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> *A lot of us mostly, I mean with placements we've also had to do our part time jobs or whatever we're doing, on top of that we also have our course work to do, usually an assignment we've got to do. We've got the placement where we're working full time, an extra job probably at weekends or whatever and course work on top of that.*
>
> *I managed, I had a little bit of an overdraft but I managed to pull through. I had a student loan as well which I paid off when I got this job (..) because I didn't like it hanging over my head. And I had a part time job in a pub as well.*
>
> *...my Mum and Dad basically gave me the equivalent of a grant, but it didn't even pay for my accommodation and they sort of gave me enough really to live on and pay for my accommodation. But I just had to have more money and I'm overspent up to here. I've got so many debts.*
>
> *From the students' point of view I think living on a grant is the main problem, financially. Depends on the amount of support they get from parents otherwise. But I think it's always underestimated, the effect it's going to have on them as learners, thinking about what they are going to eat.*
> Lecturer

10.1.7 Comparisons of diploma and degree level pre-registration courses in nursing and midwifery

Strong expressions of resentment were voiced by undergraduates regarding the inequity of funding levels for nursing and midwifery students studying at degree and diploma level. These undergraduates felt they were actively contributing to service, albeit in a more informal way than the 1000 hours of rostered service stipulated for Dip HE Project 2000 courses, due to an abuse of their supernumerary status in clinical practice. However, undergraduates received neither similar levels of remuneration to the diploma student bursary[6], or the associated perks of subsidised accommodation and travel expenses:

> *...you are on shifts and because you can't ask for every weekend off and every Monday to Friday, nine to five so you can get a bar job in the evening and a bar job at the weekend. You need to have a salary and I think it's just such an awful feeling. And it's bad for your morale when you can't get that extra money because you are working on the wards. Sometimes you are counted in the numbers and the supernumerary status doesn't always apply, and you feel you are sometimes being used as umm, as an extra bank staff and the NHS are getting a good shift out of you.*
>
> *I think the problem arises when you do end up covering shifts and are being used as a midwife and not getting anything back for doing that, getting a little thanks at the end of the day for making up numbers.*
>
> *I think we did feel very strongly about this, (...) it became confrontational, (...)we took our case to the union to say we should be able to have weekends off in order to*

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[6] With the exception of one NHS bursary funded pre-registration midwifery degree, as previously mentioned.

> *work and this was turned down by the university, the lecturers. But we felt really that as students we weren't being paid extra through our grant or anything, we weren't being paid by the health authority, so we weren't getting any extra money as nurses in the wards (...) for doing weekend working and lates and things. But the university were adamant that we did this because this was part of you know, training to be a nurse and also they felt that we shouldn't expect, you know, remuneration for working weekends because actually it's the wards that are teaching us. I mean in my position, I can see the point but I mean as a student you've got to have something to live on, you've got to be able to have something to eat. (...) And I think the money as a student is very, very poor, and compared to Project 2000, I mean they moan all the time about their money, which was double what we were getting, and their rents were a lot lower as well. I think that we had a just case and I think it was a pity that it went to confrontation.*
>
> *I think the financial side of it has become more of an issue recently, when I first started the course, especially the first 18 months, because we were in the university more than we were on placement, we identified as being students, and like all students are skint anyway. But like now we are on placement a lot more and you're seeing other student nurses that are doing the Project (2000) course and they are (...) not hardly paying any rent and you start to compare with them.*

The differences in funding for students nurses and midwives as undergraduates on LEA grants, and diplomats on NHS bursaries are set to become more sharply contrasted as both types of students increasingly find themselves studying side by side. Institutional integrations are leading to greater numbers of faculties, institutes and departments offering pre-registration courses at diploma and degree level. One lecturer describes the delicate situation which staff and students now find themselves in:

> *...it is openly known that the undergraduate students are not bursary funded. A lot of them are entirely reliant on parental support and many of them at the moment are having to take part time jobs to actually just exist. And the diploma students are aware of this and so have their teachers been and they are very understanding and respectful. There haven't been any difficulties, there has been a mutual appreciation that the courses are different, there are different endpoints but there are some hardships and how can I put it ... inequalities...that this institution and many others have to address and we are doing our best to address that through the usual professional channels, the ENB and so on.*

10.2 Part time work

Increased financial hardship has resulted in a growth in the number of HE students seeking part time work during academic terms, as well as more customary work during vacations. Concerns about the potentially harmful effects of such work on academic standards have been voiced (Targett 1994; Times Higher Education Supplement 1994).

As this chapter has already shown, many undergraduate nurses and midwives find themselves in financial difficulty, needing to generate income through employment to stave off growing debt. Students on some four year degrees have more holiday time in which to work should they need or want to. Students on three year degree programmes and four year courses of 40 weeks or more have more limited vacations, but many use some or virtually all of this time for paid working. Such students are effectively engaged in cycles of holiday working to attempt to clear accrued debts and start the next academic session with less financial worry.

A national study into nursing student hardship by the Royal College of Nursing Association of Nursing Students revealed that almost two thirds of Project 2000 students and two fifths of undergraduate students worked as agency or bank staff to supplements their income. Project 2000 students spend on average 31 hours per month in paid employment and more than one in four students works in excess of 40 hours per month (Royal College of Nursing 1994).

On one three year undergraduate programme participating in the TYDE project, students were asked to provide information on paid employment undertaken during their course in an optional section of a written review. Sixty five percent of the students reported some form of employment, as care assistants, cleaners, bar work in pubs and clubs, shop assistants and working in a cake factory. Whilst this survey and the Royal College of Nursing survey (Royal College of Nursing 1994) provide indications of the extent to which students are engaged in part time and vacation work, generalisation of this issue remains difficult.

From the TYDE project data it is possible to present and explore individual accounts, of the range and amount of work undertaken. At one end of the spectrum, students reported never having worked during their course, others only worked during vacation periods, whilst more worryingly there were accounts of students engaged in part time work during academic terms and vacations to an extent which appeared to be excessive, and which students and lecturers identified as being potentially or actually detrimental to their work. Of this later group of students, part time work was a necessity to keep them (and sometimes their families) financially afloat:

> *... I mean we were working 36 hours on the ward and then I was in the pub (...) Tuesday, Friday and all day Sunday. (...) Doing shifts and then the written work on top as well.*
>
> *Yeah I do agency nursing, about four or five hours a day after college at the moment to pay off my overdraft which has got to be paid off by June, so in the meantime study means nothing, I've just got to pay off my overdraft. I haven't even seen my grant cheque because that has gone on rent. I've got £15 to last me 'till I get my pay cheque at the end of the month.*
>
> *A lot of us mostly, I mean with placements we've also had to do our part time jobs or whatever we're doing, on top of that we also have our course work to do, usually an assignment we've got to do. We've got the placement where we're working full time, an extra job probably at weekends or whatever and course work on top of that.*

Whilst not exclusively, many of the students reporting high levels of part time work were studying on three year degree programme (and indeed the three data excerpts are from students on three different three year undergraduate programmes). Choosing a three year programme as opposed to a four year one means one less year on student money, however the decreased vacations of three year programmes provides less opportunity for working during holiday periods. Students on four year programmes with more limited vacation times also face this problem if they are reliant on earning for financial survival.

Students who worked during academic terms and limited holiday periods reported conflicts of interests. Working during the six or seven weeks of annual holiday does not provide a break from the demands of the course, to rest and recuperate before facing a new term. Working during term time whilst also attempting to keep up with the rigours of academic work and clinical experiences creates conflict with the need for cash; students must weigh up their financial situation with the potential compromise of their learning and course work demands:

> *I had a part time job as a barmaid and I used to do that two nights a week, at least. But that's stopped now because you just have to prioritise, the work is the priority in the third year, that's how I feel anyway.*
> (Finalist on a three year course)

> *(I worked regularly during) the first and second year. The third year, I didn't work very much during the third year of the course. I think with the amount of work we had to do with our dissertation and revision for the exam I cut the hours right down and I only did odd shifts in holiday time.*

As this student relates, choosing not to work can result in a rise in level of personal debt:

> *...well it's a lot to me but perhaps I don't think it's as much as a lot of people have got, I had a £1,000 overdraft and I had two student loans at £600 each. So it's quite a lot now (laughs), when I've got to pay it back. (...) I got my first student loan in the third year, (...) and it was only in the last year that I struggled because of the dissertation, because I didn't work in the Christmas holidays or the Easter holidays and that made such a difference. Because in the first two years I didn't have an overdraft because I was working so much in the holidays.*

The combined effects of juggling heavy loads of academic work, clinical experience and part time work are physically and psychologically exhausting and create considerable pressures:

> *But I think also the problem with working (is) you get so tired, I mean I'm just, to be honest we've got so much pressure I mean I just snap at the kids all the time, it's like, I mean they can't do anything right, the slightest little, "Can I..." and it's like, I just bawl at them, it's just basically the pressures and being so tired. But I mean what can you do? You've got to do it.*
> (Mature student and single parent)

Lecturers are acutely aware of the financial difficulties increasingly being experienced by undergraduates, driven to seek employment in term time. Whilst sympathising with their need to work, there is a growing awareness of the time leeched away from study:

> *I suspect quite a few of them are (working) I don't see how they can survive if they're not. (I) always discourage doing work as a care assistant in agency early on. I know it happens in later students, so third and fourth year I would expect them to do it…and getting tired. But life is life and they've got to eat.*
>
> *Inevitably it does mean that there isn't as much time available for private study, and we have had cases where a couple of students have got into serious difficulties in meeting course work deadlines and also become very stressed at the anxieties caused by just having to eat and pay for food and lodging and travel. I think it has also encroached not only on their academic lives but on their social lives. So it is worrying and it is growing, and I am very worried that of it continues to become an increasing problem that we will see very negative effects in terms of students' academic and professional performance.*
>
> *One of the things that does worry me, is their income (…) almost all of them supplement their income in some way or another, you know, either in nursing homes, working as nursing assistants or in bars or record shops or Lord knows what, and that's bound to have an impact on the time they can spend on study. And I find that very worrying 'cos that is out of our control. And as a university we conduct projects into it (…), all of which have stated the utterly blindingly obvious, namely that students that are distracted from their studies by having to earn a living, they can't perform as well.*

One lecturer expressed her belief that despite students choosing to do agency work at convenient times, employer pressure to work at other times at short notice create difficult dilemmas for students. The detrimental effects of combining part time employment with clinical practice and academic study were expressed as a worry:

> *…these students are working as auxiliaries (…) or stacking shelves just to support themselves (…) and if they miss a placement it looks bad on record at the hospital (…on) the next student that comes along…*

Indeed some students did report pressure from nursing agencies; pressures that were hard to resist:

> *It was hard at times because once you start saying yes, they expect you to say yes all the time and go in as soon as they ring you.*

10.2.1 Part time care related work – who benefits?

Some students saw a positive aspect to their part time work in nursing related or caring settings, helping them to increase their practical skills and confidence:

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> *They give you as much responsibility as you want to take so you're treated like a student nurse sort of thing, and they just like drag you in.*

> *…you have to do it, and it's really good experience. They treat you as student nurses so you get a lot out of it.*

> *A lot of us have experience doing auxiliary work during the holidays, so you gain so much experience doing that, I mean I spent the whole of the summer working in the hospital, I know a lot of the girls have done that and we've picked up tons that way.*

The benefits of such experience for students were also expressed by one educator who reported her contact with a local agency to ensure that student were working in appropriate areas. Indeed students may benefit from the skills acquired whilst working as care assistants, but it is a fine line which students tread when roles and responsibilities are extended:

> *…I started when I wasn't a nursing student, as an auxiliary nurse and now they expect more of me. It's not so easy now I'm a student so they'll expect me to do blood pressures and do the admissions and stuff when they are stretched and that 'cos they know I am a student.*

Uncontrolled exposure to practice without appropriate support and subsequent debriefing has implications for student learning. Issues of accountability are also raised when the roles of students in paid employment as auxiliaries or nursing assistants are extended for the purposes of 'learning'.

One result is a distorted curriculum. In these circumstances the notion of a controlled induction into a profession cannot be implemented. Clinical experience acquired by students in the form of paid work as care assistants represents an induction into occupational life, culture and practice which is neither organised, selected or debriefed by their tutors. This experience belongs more to an apprenticeship tradition than a professional aspiration, but it constitutes a significant and presumably formative element of the student's development.

Finally, as has already been noted, undergraduates required to work excessive hours in addition to their studies and hours of clinical practice in order to survive financially face detrimental effects on their health, well-being, academic grades and the quality of their learning. The potential for detrimental effects on patient care must also not be overlooked. One graduate reflects on her experiences as follows:

> *Very often I would do an early shift, from seven 'till three thirty, then I would go straight to work and do a chunk, from about four to 11, then I would go home and study and then I would get up in the morning to do another shift. (...) Now, about 18 months on, I realise just how hard I worked and I hope I never have to work that hard again in the rest of my life. But I survived and nobody died! (laughs) for which I am very grateful. (...) I am just aware that a lot of junior hospital doctors work the same hours that I was working, and I am not saying that it's their fault, but people do die. And I think that is something that we do have to take seriously. I think*

> *paying someone £2,000 a year to be a student, if peoples' lives are depending on it , may not be the best way of funding a course.*

10.3 Summary

For these students learning and earning go hand in hand, the ratio determined in each case by a personal calculation of economic survival. They learn what they can afford to learn, they earn what they must when the work is available. For many it can be a desperately difficult equation.

Even students of independent means who can afford the cost of living, compulsory subsidise to the delivery of care in the form of their unpaid labour when supernumerary status on clinical placements is abused, and on some courses there are costs of compulsory electives in faraway places; even they find the combination of academic and clinical demands in long, overcrowded student years a tremendous strain.

As has already been pointed out, these are not problems confined to the three year courses and they raise fundamental issues of funding, curriculum design and delivery. There is evidence of student grant assessment that is inadequate, uninformed and unfair. There is also evidence of demands of professional courses which exceed undergraduate norms, and take little account of the study time that is realistically available to students in such circumstances.

In summary:

- LEA grants have been frozen and are being subject to a 30% decrease over the academic years 1994-1996. Meeting day to day living costs is increasingly difficult for students on current levels of grant;
- Students are increasingly reliant on alternative sources of funding – either parents or a spouse, student loans, bank overdrafts and part time work;
- The effects of students financial situations on learning resulting from worry, stress and increased reliance on part time work, are of growing concern to both undergraduates and their lecturers;
- The personal financing of diploma level Project 2000 and pre-registration midwifery students on NHS Bursaries and undergraduate students on means tested LEA grants is disadvantageous to undergraduate students;
- Completion of an undergraduate course in nursing or midwifery in debt was widely reported by those not fortunate enough to be adequately supported by parents or a spouse, or who chose not to work in the face of limited finances. Repayment of debt by graduate nurses and midwives is not favoured by the starting salaries in these professions, which are below in the national average wage;

CHAPTER TEN

Student finances and part time work – some implications for learning

- Undergraduates on professional courses face additional costs, most notably travel to, and sometimes accommodation at, geographically dispersed sites for clinical placements. These costs can be considerable, and unlike students on NHS bursaries, financing for travel is not guaranteed at all institutions and rates of accommodation are seldom subsidised;

- Discrepancies in funding between diplomate and undergraduate pre-registration students will be increasingly apparent as integrations of institutions continue; diplomates and undergraduates will be in closer proximity for learning in HE institutions as well as clinical areas;

- Given this situation, it is anticipated that the financial circumstances of potential recruits into nursing or midwifery may have increasing impact on the choice of a diploma or degree level route to registration; i.e. an undergraduate route may be an increasingly not viable option for candidates with limited financial resources. This gives rise to concern about issues of access and equal opportunities for candidates;

- As levels of LEA grants decrease, students with limited financial support are undertaking part time work;

- The nature and amount of such part time work is variable. depending on individual need; in some cases needs are great;

- Where individuals do report high levels of part time work during term time and vacations, to support themselves financially, this may be at the expense of time for reading, learning, reflecting and meeting the demands of the course. Incidents have been reported of students experiencing severe academic difficulty;

- There are important implications of part time work acting as unsupervised experience in clinical areas; such practice is not-debriefed and may influence learning detrimentally.

CHAPTER ELEVEN

A different kind of student role: creating pressures and providing support

Introduction

This chapter explores aspects of undergraduate nurses' and midwives' experience which they identify as being different to that of other related groups of students, such as undergraduates on other university courses and to student midwives and nurses on diploma level courses. Some of the issues are not mutually exclusive to undergraduate midwives and nurses, but are common to students on other professional courses, particularly in health related fields. Some differences are as a result of national innovations such as pre-registration midwifery, whilst others represent local innovations, such as a new undergraduate programme. Yet other aspects of the students' experience are familiar from literature on undergraduate nursing education (Luker 1984; Sinclair 1987; Ashworth & Morrison 1989).

Undoubtedly, the pressures of three year programmes anticipated by the Polytechnics and Colleges Funding Council (PCFC 1989) and the commissioning brief for this project are a reality, however pressures are not confined to three year programmes. This pressure can nct be reduced to an issue about time; rather it is an issue of how within the time period adopted, resources are allocated and employed. There is potential for pressure in all courses due to the very nature of the academic and practice demands, course organisation and structures (and their maturity), and the length of the academic year. Issues of pressures are explored, along with sources of support for students.

Finally, this chapter would not be complete without reference to the high levels of individual and collective motivation for nursing and midwifery undergraduate programmes which have been evident in all phases of data collection. Nor would it be complete without reference to the too often experienced draining of personal reserves of health and energy that such commitment leads to, in the absence of adequate resourcing and in the face of rapid change.

11.1 Experiencing a professional degree

Undergraduates in nursing and midwifery have fuller timetables compared to many of their peers in the more traditional range of academic subjects. Students and lecturers comment on the need for a heightened sense of responsibility and maturity associated with the challenges of professional degrees which are intellectually, emotionally and physically demanding.

> *These courses are physically and psychologically shattering type programmes. There's no doubt about that.*
> Lecturer

> *Certainly the students do complain that they're under enormous pressure, that the work load we give then is not commensurate with other undergraduates within the university.*
> Lecturer Practitioner

> *It's not quite as easy as everyone like doing history has it. They just seem to have half as many lecturers as us and you can't go out really late if you've got to do an early shift the next day and things like that. And you tend, I find I'm tired quite a lot as well so I don't have quite as much energy.*
> Student

Undergraduate nurses and midwives soon have to learn how to handle the competing demands of multiple roles of university student, student nurse or midwife in practice settings, whilst also maintaining existing roles such as parent, spouse or partner, or developing new identities, for example independence from parents and the transition to adulthood, and, in many cases, part time worker:

> *It is a pressure to try and be wearing different hats all the time, to be different people and you can't always be.*

> *It is confusing because you are not a proper student nurse, but you're not a proper student because not a lot of proper students get up at ridiculous times in the morning and go and work.*

> *I mean I really enjoyed being a student. Umm, I think that in terms of leaving home it's really a good way of leaving home, because you've half left home and half haven't.*

The sequencing of HE based and clinically based learning activities can create periods of integration with, and isolation from, the mainstream undergraduate population. Initial foundation studies are often a time when undergraduate nurses and midwives report greater integration with other students, as they are physically present at their HE institution for longer periods than in later years. This has an impact on the extent to which undergraduate nurses and midwives are free to choose to participate in university or college life by joining societies or clubs:

> *…we didn't go on the wards for ages initially, which was a bit strange really in a way because we were just like students, just like any other student. Umm and some people complained about that and didn't like it. But I think it was really good because yeah, because it's such a unique thing being a student, like at university, I think to have the chance to experience it was really good. (…) after the first 18 months we weren't really like other university students because you've got to be more responsible because of your work.*

As Chapter 4 outlines, content and timetables vary from course to course, however restrictions on the choice to participate in student activities are commonly experienced by students due to clinical shift patterns and requirements for academic attendance in:

> *...like sports and things, it's say every Thursday, but if you are (on) a late shift, you can't do it, or if you are on an early the next day, you might not. You can't ever really commit yourself to anything because you don't know what you will be working.*

Attendance at clinical placements is often portrayed as 'work' by undergraduates, and the unsociable nature of shift work further emphasises difference with students on non professional courses:

> *You don't seem to have any social life. You go home and you work, and then you come back and you work (laughs), and you get in from work, off your shifts and you're working, it's just non-stop.*
>
> *I think also you've got more responsibility. I've got friends who I know from the first year living in Halls (of residence...) and they were always saying, "Do you want to come out?" And I'm like, "Well I'm on an early shift tomorrow, I've got to get up at five." And they are like, "So what?" and I sort of (say) "Have you ever tried it?"*
>
> *I don't know, you feel like a student in a way, but then again you feel a bit of a student that's different, I don't know what...when I talk to friends who aren't nursing students I feel, well incredibly dull actually because they're like always going on about what they do and I feel we either very hard worked or I feel like I'm doing a proper job.*

11.2 Intensity of pressure

11.2.1 Extended academic years and time

Pressures are experienced by students irrespective of the length of their degree of study. However, accounts from students on three year programmes and intensive four year programmes with extended academic terms and limited vacations stand out:

> *I think Zoe has just hit on a word that could describe the course entirely which is intense, the course has been very intense. The first year wasn't too bad, but in the first year onwards, it's like one thing on top of another.*
>
> *And also because it's a three year degree and we're getting less time for reading weeks or whatever to actually do the work that's involved, you know, you either...your studies suffer and you stay alive by getting the extra money, or you forgo that extra money and you try...but even then you are using all your time directed towards the course and not anything external, it's still very intense, the amount of reading that they actually expect you to do, it's always done off your own back.*

> *...it's like being a hamster on a treadmill, you daren't fall off...*
>
> *I think the students do feel pressurised, it's a constant treadmill for them in terms of constant assessments and combining the university work with the placement work.* Lecturer

Undergraduates have limited periods during which they feel able to 'switch off,' to relax and summon up mental, physical and financial resources to face the forthcoming term:

> *...we were slogging our guts out at the same time as everybody else was slogging their guts out, but then we didn't have the holidays (laughs) to compensate. And I think that that's perhaps the hardest, (...) it'll be really hard whatever course you did, however long it was, but the difference is that we just didn't have the holiday in which to let our brain recover.*
>
> *You need to crash. You don't seem to have time to go out and do stuff, I mean you do do it, but you either feel guilty that you are doing it or you're so tired that you don't.*
>
> *I think there's times when you think, "I need a break." And two weeks doesn't seem like a break.*

The benefits of substantial vacation periods during demanding courses are clearly expressed by the following student on one four year programme:

> *The third and fourth years were hard in terms of the...you had a lot of ward work and a lot of academic work on top but I think (...) at least we had our holidays and we could de-stress during the holidays. We had a lot of time, especially at the summer and over Christmas and Easter...where it was almost the light at the end of the tunnel, you could cope with what you were doing 'cos you knew in a few weeks time you would be on holiday (...) that was always a motivating factor knowing that your holidays were coming up and then I used to totally switch off from nursing if I could.*

But, as Chapter 10 outlines, some students are not able to relax as much as they would like, and also perhaps need, to during vacations (whatever their length) due to their needs to earn money and finance their studies.

As three year degrees in nursing or midwifery are required to be a minimum of 45 weeks each year in order to meet ENB requirements (see Chapter 4, section 4.3), increasing vacation time for students is impossible. However some course designs acknowledge and respond creatively to the intensity of the undergraduate programmes by identifying and realising the need for 'down time' for both students and tutors:

> *...first of all you have to be aware that the students are under this kind of pressure (...) we have weekends away, we have course enrichment activities, we have days when we get all the students bunched together...*

> *There's considerable independent learning, reading days, and to be frank, rest and recuperation type days because of the environs, they need the time…*

Regular dialogue between undergraduates and staff which is characterised by mutual respect, frequently precipitates positive action which can curtail or reduce aspects of the course which induce pressure. This time for discussion and reflection on all aspects of the course facilitates the sharing of experience between students and clinical and academic staff and facilitates a collaborative learning culture. Where action cannot be taken, shared understanding and empathy of the situation may nevertheless help relieve student anxiety or frustration. For example, relatively minor problems of timetables for academic or clinical activities, or the timing of assessments, can often be tackled. Where this is not immediately possible, students can be informed of action being taken on their behalf which may lead to change at a later date. If however students feel constantly beset by problems which do not appear to be heard despite their vocal action, the effect can be demoralising and disempowering, a situation which is incongruent with course aims.

Students identify their own important needs for 'down time' outside the course, to rest, relax and take a break from pressures. Many student stressed the importance of playing hard as well as working hard, and group nights often provide a good opportunity to let your hair down:

> *…Friday night I go out with my mate Shelly rather than go out with my husband, I know it sounds awful but she can relate more to what we've been going through, what we've been doing…I mean I go out with him and he sits and talks about football and I'm thinking, "I can't be bothered with this," and I just need somebody to load off onto and to know…and I need to just get out for a bit to not be a mother, not to be a wife, not be a student, or a nurse, just to be me.*

Such 'downtime' is a curriculum design issue and is a necessary feature of a learning process. It poses the question of whether coverage is being sought in a degree (whether three or four years) at the expense of the time necessary for reflection on, making sense of, and integrating experiences (See Chapter 14: Principle 7.1).

11.2.2 The final year of study

The issue of the intensity of final years of study emerged clearly in the data from graduands, graduates and lecturers. Naturally, undergraduates are required to practice and to display high levels of academic achievement. The volume of work to be completed in the final year is substantial, and significant in terms of its contribution to honours classifications. Students on both three and four year programmes reported greater pressures as their courses progressed. Although students are successfully reaching honours degree level on both three and four year programmes (see Chapter 12), pressures associated with the final year of study, should not be underestimated. This was a particularly clear message in graduate and lecturer data from three year programmes:

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> *I would say that like that last term there was an awful lot of work to be doing really, but umm…I mean and I know that a lot of people definitely ,really thought that that was quite a lot to be doing all at once. I mean we did have supervision for both the care study and dissertation and like your supervisors would encourage you to get things done and sort of pace you, but still for a lot of people it was sort of in the last term when sort of the heat was on to get it all done really. I mean really the last year is quite stressful and there is a lot to get in there. I think umm, I remember, 'cos we kept thinking something like 21 / 25ths of our degree were based on our final year, I think it was quite high.*

During a time of intense academic activity, students are also at a crucial time of developing competence and confidence in their practice:

> *…I described myself as a wild woman at the time (…) trying to get things done…my personal experience of it was having done all the donkey work for my dissertation and care study, that is getting to libraries, gathering up all the, you know, photocopied journal articles that I wanted to use, well that sort of took about a term to do that and then I had the final term in which to write these things, projects up (…) it was about seven or eight weeks that I was probably working about a 17 or 18 hour day, every day, seven days a week and I found it…very, very stressful (…) I felt that we were being pushed to our absolute limits…especially as I've got three children (…) so I really felt like I was being spread extremely thin and umm…also because I was good at what I was doing I had my own caseload anyway in the community, so it wasn't as if I could unload to anybody else, it was work that I felt I, I you know, specifically felt I needed to be on top of…people's sort of lives and things that you are dealing with.*

The cumulative effects of academic, professional, physical and personal pressure have terrific impact on all aspects of undergraduates' lives:

> *I think towards the end of the final year we were all so tired because it really was quite a hard year. I think anything could have set you off really. You could get upset by the least wee thing.*
>
> *…it was the hardest kind of nine week term period…nine weeks that I'd ever worked in my life and umm…I felt a little bit annoyed that I was deprived of being able to spend time with the children, because there was just no time for that other than doing the basic things.*

Lecturers were acutely aware of the intensive nature of the final year of three year degree programmes:

> *…but there's no doubt that the forty-six week year is err, you know does exert extra pressure for all concerned for a range of reasons. Despite the fact that overall the outcomes have been extremely positive and we, I don't think we've lost any students because it was a three year rather than a four year course for example. So I think that's a useful rule of thumb, the attrition base and so on was low. But the length of the academic year and the fact that students are constantly having to produce work*

> *or at on placement or whatever um and the very limited academic/theoretical time that they have in the third year when they're doing their dissertation, personally I think it's a big problem. If you actually add up the number of hours that they have which are branch related they're fewer than at any other time of the course in terms of their, the clinical relationship because so many hours have to go on dissertation. Um and that for me is one of the biggest disadvantages of the course away from the pressures issue, which you know one wax lyrical over, but having said that um while we are the first to recognise that there are things that we could do to improve the course, overall considering that it was the first cohort it's gone incredibly well.*

It should also be noted here that the data gathered for the TYDE project relates to the first and second cohorts of undergraduates completing three year undergraduate programmes, and that evaluation of the timing of assessments in the final year of study is being rethought in some cases.

Undergraduate programmes in nursing and midwifery are demanding by their very nature. Three year programmes of 45 weeks a year, and four year programmes of 40 weeks or more duration create further intensity for students, and the particular pressures of achieving clinical competence and academic achievement at honours degree level in three years should not be under-estimated. This intensity, as described and argued throughout this report, is at least in part a resource issue and in part a learning environment and curriculum design issue. Nevertheless, students do achieve success, and together with that of the staff, their motivation and determination act as key forces driving and sustaining their hard work.

11.3 Student support

Students require support from a range of groups and individuals to meet their particular needs, and sources of help include peers, family and friends, lecturers, clinical staff and agencies external to the course such as student counselling and welfare services.

Peer support is an overwhelming feature in undergraduate accounts of coping with course pressures. Many undergraduates and graduates interviewed for the project reported forming close relationships which proved to be invaluable, and a strong sense of cohesion and identity was noticeable within cohort groups.

> *...we've become our own life support system! (laughs)*
>
> *...there were people in far worse situations than myself, for example some of the mature students that had kids and very low budgets, and (they) still attended all the time, and did very well and gave their lot to the group. I think that's a big issue, that we were a very close knit group, and yes there are some university courses where if you don't turn up nobody gives a toss, but we were a very close knit group and we relied an awful lot on each other.*
>
> *(Our year group) actually works quite well, everybody mixes in well...it's not split by age or anything, everybody just mixes.*

Being able to share experiences and feelings, let off steam and be understood are at the heart of the group cohesion and peer support:

> *The pressure of home life and trying to combine it with the study and everything else, the pressure about the money and what's going to happen to this…I don't tend to…I have turned to some people in college but I tend to turn to other students because they know how you feel better.*
>
> *I'm on my own, I live in another house with three other students and I just come home from work and I just want there to be somebody there for me so I can have a hug and I can cry, and I can just say, "It's just so unfair." I just want to have some money and I want not to be tired and I want to pass my course.*
>
> *I can just go and probably sit in her flat and cry for half an hour and that's fine, you know, that's not a big problem .(…) I don't want people to feel sorry for me, I just want to be able to go somewhere and just to release…I want someone to know how I feel without me having to explain how I feel.*

Some student groups drew on their collective strength, particularly when expressing opinions to effect change:

> *We made comments but I think in the end we became know as like an aggressive group…because we weren't volatile, but as a group we were very strong and stuck together.*

Other close knit groups felt they had earned a label as a consequence:

> *…the group felt demoralised (…) and we got a label, I think, well we all felt – I don't know what the lecturers feel about this – but we felt we were a group, that was labelled, we used to get instances of visiting lecturers coming in and saying, (…) "Oh so you're the group that blah, blah, blah."*

The strength of group identity can create problems if certain students feel excluded, and the following extract from an interview with a graduate reflecting on her course indicates the need for sensitivity to group dynamics:

> *I also had support from other members of the group, but on the other hand there was this quite cliquey feeling to it, which I think wasn't sussed out or perhaps dissipated early on by the lecturers, more could have been done in that way. You know, I think you've got to sort of look at the sort of social side of a group as well as the academic side.*

Support from friends and family is also valued highly, and spending time with others not involved in the course is regarded as essential by some undergraduates:

> *I've made an issue of not living with nurses because I go home and talk about it for ten minutes to people who know nothing about what I'm talking about, but will just listen and not sort of want to discuss it any further and then you can forget about it.*

> *And I think that's something that's really…if I didn't have that I think I would have given up nursing ages ago! (laughs)*

Some students use friends as an alternative means of academic support particularly if this is lacking from the more formal sources:

> *…when you come to doing things like research projects and dissertations, you know, you don't get any input from the wards about that at all. Whereas your friends are all doing projects and just the academic rigour and things like that, of referencing, you share ideas and you know, they understand what you are doing.*

> *…when I did my course the nurses on the ward still weren't that familiar with the degree course and we couldn't share with them that academic part of the course really, and you needed your student friends just as much as you needed the nurses on the ward.*

Lecturers provide a variety of formal and informal support for students both academically and clinically. All courses assign individual personal tutors to students, usually nursing or midwifery lecturers. Lecturers also act as links between the academic and clinical areas. Some courses identify academic tutors (in some instances drawn from relevant non nursing/midwifery disciplines in a school/faculty) to discuss student progress. Year tutors or module leaders frequently act as key sources of support, and there is opportunity for developing effective communication between staff and students.

Students on some courses report excellent, supportive relationships with staff, characterised by mutual respect, regular communication, accessibility, time to talk and staff awareness and understanding of students' current preoccupations:

> *…like I've had four big funerals, like close family ones while I've been on the course and there's no hassle about having time off, "You have as much time off as you want." It's like little things, like everyone is so nice.*

> *They are well aware that we've had difficulties, they are well aware that we need to have time to concentrate on learning both sides of the course.*

> *We've always got their home 'phone numbers and I've often 'phoned them at home.*

Consequently even though students can be experiencing significant pressures on the course, support from staff can contribute greatly to resolving problems and reducing overall stress:

> *I mean it's not, we've painted quite a bleak picture up to now but on a more positive light we've got such supportive tutors who are very flexible.*

> *And they've really got a lot of personal interest in our well being, when we have like progress interviews and stuff, and you really do feel like the person you're talking to really wants to know how you are feeling, wants to help you get rid of some of the stresses and strains or whatever.*

> *It sounds terribly critical. I think the thing to underpin all this is that the teachers really tried, really tried. That doesn't alter the fact that I think the students had a terrible time.*
>
> *The fact that any students have stayed at all is in my view a miracle. They have had the most horrendous programme. The only consolation that we have been able to offer them is that individual staff have fallen over backwards to help individual students find their way through the mess.*

Small group size was identified by some students as a supportive factor in relationships with lectures:

> *...there was only a few lecturers, but again there were only a few students so it, we all felt supported, which I think is the main thing as a student.*
>
> *...when you needed help with academic work you could always find someone around here, whereas the students (on Project 2000 Dip HE courses), from what I can gather, had to make appointments to see their tutor for possibly in a week, in a weeks time, whereas we could come down and find someone here.*

Continuity of relationships with staff is also important, with disruption caused by turnover of staff:

> *I've just had my third personal tutor now, (laughs) so we've had changes. At the moment though I think (she is) very good, but we're only going to have her for three months, maximum of three months, so there you are. My last personal tutor I think I saw once (...) for the bulk of the course, and prior to that I mean, very little. It depends on your tutor, it depends who they are, how busy they are, how much input they have on your course.*
>
> *...initially we had a cohort leader and then she had a baby and disappeared off, and we had another cohort leader and then she came back and we had her again, and then they decided that wasn't going to work 'cos she was gonna look after the first years...so we had the other person back again, who nobody particularly got on with at the time.*

The accessibility of staff is a key issue, particularly for students based at multi-site institutions, and when students are on clinical placements which may be located at a distance from educational sites. When students are physically unable to get to the see staff, contacting them by telephone is sometimes difficult and the situation may at times be further hampered by full answering machines:

> *...when you 'phone up college it's quite difficult to get hold of most of the tutors... the timetables can be part time... if you're actually in college you can track them down and get some time in your diary. When you're on placement, because you're now at the end of the 'phone waiting, you don't know where the person is, that's*

> *when it's hard if you are actually asking for help you can't get in contact very easily.*

Pressure of work on lecturers appeared to be a major contributing factor to students' difficulty accessing them when in need. One student gave a rather wry summary of her impressions of staff accessibility:

> *"And if you've got any problems, come to my room, but I won't be there, I'm never there, but if you've got any problems, you will find me there, but not today, or tomorrow."*

Where staff are pressured by demanding roles, both they and the students are often acutely aware of the limits which such pressure imposes:

> *I've got one student who is cracking up who is taking a whole lot of my time last term, and all of that comes out of research time because you can't take it from teaching time 'cos that's timetabled, and administration time you've got to do.*
>
> *...a lot of the staff feel that nobody cares about the staff and that is then reflected in their attitude. But I just, I don't know, because sometimes students, I mean they can at times be quite demanding, I mean you know numbers of time spent on the 'phone or when they come and collapse on your desk or whatever, and I do understand there is a need for that, but it's really difficult knowing how much pastoral support we're supposed to give, but at the same time they can't get it anywhere else because for instance student health is inundated, I mean they are... I was told recently that in order for a student to get an appointment with a counsellor at student health it would take two months. But when a student comes to see you and they're at crisis point, they can't wait two months to see a counsellor, and a lot of them actually do need counselling. I mean things happen to them, this city is not the nicest of areas to live in. A couple of years ago I had a student who was knocked off her bike and threatened with rape by four blokes.*

The amount of academic and pastoral support required by, and given to, undergraduate nurses and midwives by lecturers was a problem at institutions where lecturers had heavy, demanding roles. This was often exacerbated where small teams of lecturers ran undergraduate courses and hence acted as the main source of support for students. Extended academic terms of 45 weeks per year also meant that lecturers had little respite from students; this was reported to be very wearing for staff:

> *I think the key thing that is significant to me is that the ownership of the course and that rests very much within the department, now there are clearly large tracks of time that are given over to other subject disciplines like the social sciences, the life sciences, research and information technology. (...) So the students are doing their own thing around the university with other students, you know, in other disciplines. And yet the pastoral side of the job really never stops. So you know, you know, you won't find generally a social scientist or a life scientist sort of dealing with an upset student or the fact that their placement is not going right. Indeed they'll probably rightly come back to their sort of nursing faculty and that means*

> *that it's quite difficult to plan even in those relatively light teaching times of the course to be away to do some research because if problems blow up, or if a student is ill, or if there's a problem with a placement or something, they invariably come looking for the co-ordinator of that year or that branch or that pathway.(...) And it does often lead to difficulties, communication with other staff if, if the individual isn't around, you know? Umm getting things sorted, sorted out and resolved. So I don't know how you really explain that other than it is a sort of an ongoing pastoral support role which other disciplines don't particularly pick up and address.*

Again, the key issue is that of adequate resourcing. Too often the system works because of the commitment beyond the call of duty, that many staff will willingly give. Such boundless energy and commitment can not, and should not, be depended upon to save what may be a system that is under resourced for the job, a point well made by these two students:

> *... I imagine it wouldn't take much if (name of lecturer) was unable to give that kind of support to the following groups, or somebody like (name of lecturer), it could easily go down the pan, if you see what I mean, you know, people could under-achieve with their results.*

> *... my perceptions of the course is that, you know, it has been a really good experience and it has been brilliant to have done it. My concerns I suppose really are that: is it because of the individuals involved that have made it work, or is the structure safe? Could it be applied to anybody or anywhere? (...) as I sort of said about, you know, I thought the staff were very sort of supportive. Umm, you know maybe that needs to be incorporated in the structure, yeah? But if you're gonna do things over three years (...) then maybe the staff who are running that course need to be aware of the levels of support they actually need to invest in the nurse, err, rather than just say, "This is the structure" and just patching and selling it on to another college, you know, that actually needs to be incorporated within the structure of the course as a necessary requirement, I would say.*

Finally, some personal or financial problems which students experience exceed the boundaries that personal tutors or year tutors can cope with, and require more specialised help provided by counselling services or student welfare organisations. The demands made on counselling services in HE are growing rapidly, and annual reports obtained by the TYDE project from two universities reflect this national trend.

The existence of such facilities, as one student illustrates, is highly valued:

> *(the counselling service) is very good, I mean I went there in the very first term of the first year because I was quite homesick and everything and really depressed and she is really good and she is there quite often. (...) she had drop in sessions at lunch times occasionally, and yeah, it's very good.*

Such services are part of the necessary infrastructure to be available to all undergraduates.

11.4 Summary

The undergraduate experience depicted in this chapter sets would-be nurses and midwives apart from university peers who are not studying for professional degrees. For the typical student the combination of academic, clinical and financial demands upon their resources has few parallels. Stress is endemic; meeting students needs for academic and pastoral support is a substantial demand made of lecturers who are themselves overstretched. Only a high level of commitment to becoming a nurse or midwife and a high level of cumulative and irrecoverable financial investment explain the low levels of attrition, as the following chapter indicates.

Professional degrees which operate over extended academic terms create additional demands on lecturing staff and students. There is a need to ensure that resources and structures for course operation are sufficient, otherwise staff burn out will occur and students will not get the level of support they require.

CHAPTER TWELVE

The graduates

Introduction

Has the 'new kind of student' produced a new kind of professional? Given the apparent simplicity of the question, a simple answer might be expected. Given the complexity of the context within which graduates work this expectation is short lived. Moreover, it is too soon to make any definitive response. The history of educational reforms suggests that the effects of a given innovation are likely to take several decades to work through a system. Nevertheless, some issues for discussion can be raised through the perspectives of graduates themselves, their employers, colleagues and, indirectly, their clients.

The first task is to see what is at issue in attempting to define the outcomes of a course.

12.1 Defining outcomes

One apparently simple and straightforward approach beloved by politicians and public image managers is to look at completion rates which for the nursing and midwifery degree programmes are generally very high.

However, employing percentages of attrition/completion rates from courses is problematic. Firstly, initial cohort size varies from course to course thus at first glance these percentages can be misleading, as a simple illustration will show:

> Five students not completing out of a cohort of :
>
> 40 students = 87.5% completion rate
> 20 students = 75% completion rate
> 10 students = 50% completion rate

In very small cohorts (as some nursing branches other than adult nursing, and midwifery cohorts have been) such representation is a particular problem.

Course monitoring from the institutions participating in the project reveals that attrition due to failure or withdrawal from the courses is low. However without contextual information, statistical representation does not help to inform judgement about the quality and nature of courses nor of the graduates who qualify.

Contextual information can help to make attrition rates both meaningful and useful for formative purposes. For example on one nursing degree where attrition was found to be a problem, an exploration of underlying causes promoted staff to rethink a course structure which delays significant contact with clinical practice until the third year of a four year course. The delay means that some students find that nursing is not for them very late in the course. Student failure at late stages in the course has also prompted staff to examine assessment practices to ensure that students who are not achieving the desired standard are identified early, receive support and, should satisfactory progress not be made, are failed soundly. In this case attrition is an ambiguous indicator of quality: 1) if attrition is high it can mean that the course is insufficiently satisfying for students; 2) the wrong kind of students were selected in the first place; 3) the course has high criteria for passing. No doubt the list of possible interpretations could be extended. Moreover, non-misleading figures of completion are sometimes difficult to obtain as on some courses a minority of students have not completed the course at the expected point, but are required to complete outstanding work or drop back a year.

A further issue to take into account by those wishing to make comparisons is that new programmes often recruit quickly (see Chapter 5). The first cohort of undergraduates recruited onto a course (often through clearing) are frequently perceived by staff to be anomalous. They may not always possess the 'A' level points or equivalent entry qualifications which are demanded under normal circumstances (and which are subsequently obtained in normal recruitment circumstances). In addition, new programmes often require changes and alterations in practice, until they become established.

> *We were very pleased at the outcome (...) for the first cohort. I think the key things that please us are that we had a very low A level point intake 'cos we recruited to the degree (...) after an approval which was in the summer and we had little time to recruit through clearing and so we're probably talking about 8 or 9 ('A' level) points at intake level and yet 72% got 2:1's and one person got a 1st in that 2:1/1st category...which we thought was an excellent achievement (...) in terms of added value...umm despite the fact that it was a three year degree with all the practice and all sorts of issues that people have raised about that. (...) The other thing is that our understanding is that all the students were fairly rapidly employed after graduating, which again is very positive for us.*

The notion of 'value added' may, of course, be of use here in attempting to identify the impact of a given course upon the achievements of a given student. It is a term which derives from manufacturing and is used to describe the increases in value when raw materials are worked upon and transformed into some desirable product. Human beings are not raw materials like iron ore. The transitions and transformations that human beings undergo may be as a result of any one of a vast range of influences: the 'chemistry' of friendship within a given cohort, the inspiration drawn from a particular role model who may or may not have anything to do with the course, or, indeed, the quality and the resourcing of the course and the learning environment itself.

The employability of graduates, of course, is another factor that may signal their quality:

> *...we can be convinced about the academic integrity of what we're doing and we can be convinced about the professional integrity in terms of employment of the first*

> *cohort of graduates and in terms of the results they've achieved, which have been I think very, very good against the context of the recruitment level.*

Finally, all degrees included in the project were offered at honours level with two exceptions[1]. Success at honours level was also reported to be good, comparing favourably with standards across the institutions. Some lecturers commented that the degree classifications of some students did not always reflect their achievements in practice settings, however the move to give equal value and academic accreditation to practice and theory, specified by the ENB (1995 p 5.5 in ENB 1993-1995) may resolve this issue.

12.2 Employment issues

The overwhelming majority of graduates who successfully complete programmes in nursing or midwifery go directly into practice, most commonly in the NHS, which accords with recent research on newly qualified diplomates (Stock, Seccombe & Patch 1994). The with the outcomes described in the many follow ups from 4 year nursing degrees (see for example Montague & Herbert 1982; Kemp 1990; Smith 1993) and disproves many of the popular myths surrounding graduate practitioners, namely that few enter nursing practice, that the length of time in practice is limited and that accelerated promotion into management subsequently ensues (Sinclair 1987). That the majority of graduates included in the TYDE project take up posts as midwives or staff nurses appears to reflect the high levels of commitment to, and motivation for, a career in nursing or midwifery. Many courses have attempted to collate initial career destinations. For new programmes with few graduate cohorts, these databases are not yet extensive. As relatively recent innovations the three year degree programmes are a position of immaturity in comparison to well established four year programmes; of the three year degrees participating in the study, the most mature programmes produced their third cohorts of nursing and midwifery graduates during the writing of this report, whilst the youngest produced its first cohort of graduates at the same time (hence too late for their inclusion in project data.)

Of those graduates who do not go into practice, reasons given in course documentation include: personal circumstances e.g. pregnancy, child care or domestic reasons; an alternative choices of career, frequently in nursing, midwifery or health related work, including research; a remaining minority do not practice and seek work in completely different fields or are unaccounted for in follow ups but are thought not to be practising.

As is the case for the majority of newly qualified nurses from diploma programmes (Stock, Seccombe & Patch 1994), graduates are typically employed as staff nurses at the lowest point of the grade D scale, i.e. increments between £11,320 – £12,950 plus unsociable hours payments (Department of Health and Central Office of Information 1995). Graduate midwives interviewed for the TYDE project have been employed on the

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[1] One course awards a pass degree only. Another offers students the choice of study for a degree with or without honours classification, but to date all students have opted for an honours degree.
N.B. A further course (not included in the study) is a three year unclassified degree with the option of one semester study by research dissertation to obtain an honours classification.

E grade scale of £12,950 – £15,000 (Department of Health and Central Office of Information 1995). This grade generally equates to the initial grade of midwives via the pre-registration (shortened) route and pre-registration diplomates[2].

The nature of employment contracts for staff in the NHS is fast changing according to recent research (Buchan 1994; Stock, Seccombe & Patch 1994); these trends are reflected in graduates' accounts of job hunting. Permanent contracts are few and far between, and many graduates have been appointed to fixed term contracts of three, six or 12 months, often with the possibility of renewal subject to the performance of the graduate and the financial status and staffing requirements of the care area. Other graduates report temporary work with staffing banks or agencies whilst seeking permanent positions.

For graduates on temporary or fixed term contracts, hopes of renewal of contracts or finding permanent work have been high. However such arrangements can create stressful working experiences. One graduate working in the community reported her experiences having now secured a six month contract after initial contracts of one and three months:

> *I got a job on the bank when I first qualified, I was just moving around, I was at Anytown for about a month when I qualified, and got moved to New Roads and then from New Roads I got a three month contract and moved here and now I've been here for two months and they've just renewed my contract again, extended that with a six month contract. (…) I've felt a bit unsettled really moving around. Just getting used to one place and then – I've never known how long I'm gonna be at one place for, they have never told me beforehand. When I first went to Anytown I asked how long I would be there and they had no idea, and they rang me up and said, "Can you go to New Roads from next week?" So I have been a bit unsettled.*

Other graduates reported the following experiences:

> *I originally started with a, it was a three month contract to cover maternity leave but it was only part time. But because of sickness I was able to make it up to full-time straight away. So I was, I've been full-time the whole time. (…) …it was due to be, to run out at the end of March, but then I had the interview for the permanent contract on Friday and got that. (…) When they offered the permanent (the ward manager) said that she might be able to offer a six month contract as well. So I thought, "I'm bound to get one of the two." So no, it hasn't bothered me as much as it might bother others because I am thinking about moving away anyway.*

> *I am doing on a daily basis, what I enjoy doing, for all the political overtones and umm, some of the queries over practice that you get, I still love the job. (...) I look forward to doing the job more in a way that I want to do it as my experience grows and as people take me more seriously as an experienced midwife rather than as a newly qualified one. But at the moment I don't feel that I can plan for the future as I am just looking to re-apply for jobs all the time.*

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[2] However there have been reports of some newly qualified midwives commencing on D grade salaries.

For the graduate quoted above, the prospect of moving on should her contract not be renewed is not perceived as problematic; other practitioners are not so fortunate and financial and family commitments may limit their job mobility.

12.3 Developing professional confidence

One of the key expectations of educationalists and policy makers is that graduates will be change agents. As new practitioners, however, they are amongst the most powerless in the system. Developing confidence as a practitioner is daunting enough without also having to develop the confidence to change the system itself. Eventually, though, today's graduates will *be* the system of tomorrow as they mature and replace those who retire. Hence, it would seem logical that education for change with an eye to future possibilities is a reasonable expectation, albeit a longer term one.

How students develop confidence is thus an important issue to study. It is, in part, about learning that you are on your own and that you, and no one else, are responsible for what you are about to decide to do. The feeling of increasing confidence is difficult to describe and impossible to measure in any accurate sense. Nevertheless, there are pointers to its occurrence towards the final stages of undergraduates' learning. There is a sense of there being turning points where a previous stage is left behind:

> *...the second time back on the labour ward was the big turning point when I thought, "Right, this is great, I really like it." And I thought, "Right, I am going to learn all I can, do all I can, see as much as I can and really get involved," And I think definitely with something like midwifery, the more you put into it, the more you get out of it.*

There is something of the subjective feeling of being at home, being comfortable with one's self in this occupation and of beginning to identify with the profession:

> *I chose to do my elective, my elective allocation on delivery suite in a different hospital, umm, and found that was really good consolidation of previous experience, and I did feel on delivery suite as if I was working as a midwife, even though I still had a student label.*

Eventually, there is the sense of being in control:

> *I didn't think there was a lot in my last community placement that I could not have dealt with.*

On qualification there are still transitions to deal with, of course. It is not only a matter of convincing one's self, but others:

> *Oh without doubt, I mean the minute you put the blue on instead of the 'J' cloth,*[3] *there is a certain acceptance, and, you still have to prove yourself there are certain*

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[3] Slang for blue checked uniform which has been standard issue in some hospitals.

> *bastions as well in terms of staff that you have to prove yourself to, and once you have done that you are thoroughly accepted.*

Confidence is not something that is finally achieved and completed. There are always new contexts, new areas of specialism to contend with:

> *I mean I've still got all the worries of not having my confidence like I'm sure everyone else has. I think also it would depend very much on what sort of ward you end up. Because I know friends who have gone to general medicine have settled in very well. The ward I've gone to is extremely specialised and I think with added pressures because it is very, very specialised nursing.*

> *...there was a lot of stuff that I didn't feel that I knew, but most of it was about diabetes and that was because it was the speciality and I hadn't concentrated on that. It was just silly things like how a certain pump works or how a certain insulin pen or something works, like that. And it feels like something really minor but you can be fumbling with it for half an hour if you don't ask somebody.*

The graduate here calls them 'silly things' but it is knowledge not usually required of students because they are not expected to be specialists when qualified. Hence, confidence seems to be something that needs renewal through processes of updating, experience and further study:

> *Since I have qualified I have a felt a lot more confident about things I am doing and a lot more confident about saying no to things as well and that I don't want to do things and I am not happy to do things. I know I have looked at doing study days already and I mean I definitely want to keep up on my theoretical experience (...) I would certainly would like to keep updated on everything that is happening. At the minute it's getting all my experience of scrubbing, suturing all those kind of things sorted out, before I think about theoretically advancing myself.*

In sum, graduates in general feel that they have achieved competence:

> *...I feel that I'm a competent nurse practitioner, umm that I have confidence in that role and you know, that I am able to...deliver a very high standard of care to people. Yeah, I have no doubts about that.*

> *My fascination has remained the same throughout. I have always been fascinated by the whole field, and that hasn't changed, I am still fascinated by it, umm and I just want to be safe and do the best I can within the grounds that I understand and the depth to which I understand. And I think umm, that there is a certain way of looking at things, in more depth, in a more analytical and broad way that you do get from studying something at degree level, umm and I have found that very, very useful since I have been qualified. And other members of staff have found it useful.*

How this competence is actually achieved cannot be naively regarded as a straightforward direct consequence of a given course. It would be a rare course indeed where no one criticised its elements whether of content, process or organisation. In order to grasp how a sense of competence is actually achieved the focus has to turn from the course itself and towards the learning environment attendant on the course. What is learnt is a complex matter going far beyond the course itself and the teachers are many:

> *Not survival skills but life skills, you are working with people all the time, not just within your own department and colleagues and friends, you're also learning about life, leaving home and being on your own at university. And you are also learning from the patients as well, communicating with them. And I think those life skills, they, they gave you the confidence as well to actually confront things when they weren't right, to say, I don't feel happy with this particular piece of work, this placement."*

There is a real sense in which students are instrumental in creating their own learning environment through their own perceptions of the world about them. This is a process that can be facilitated in formal course design and delivery. However, every course is open to multiple interpretations. Just as each individual brings their own codes of interpretation to a given text, so each individual will bring their own codes to the interpretation of the broad curriculum as enacted through the formal and informal lessons, discussions and placement experiences. Through their interpretations they construct the essential sense of confidence that enables them to 'see' or 'feel' transition points, 'acceptance' by others and instances of 'learning'. Confidence is that unifying feeling that comes with 'knowing what to do', 'feeling in control', feeling you are an equal with others in your profession.

Without confidence particular knowledges and skills would be of little importance; equally, without those particular knowledges and skills there could be no realistic sense of confidence. Hence, criticisms of some courses focus around issues of 'knowledge' and 'skills'. Not without reason, professional cultures value particular skills and knowledge. However, what do these consist of? And how much of them should one develop during a course?

> *I think there was, looking in retrospect there was a lack of emphasis on actually knowing the nitty gritty facts of midwifery (...) I think a stronger emphasis of actually learning the* **facts** *dum, dum, dum as well as looking at the relevant research and discussing it and things. You need the combination of them both.*

The appeal here is to coverage of a broad set of 'things' that are so essential, so basic, that somehow they cannot be doubted: the facts. It matters little to those drawn by such an appeal, that many a philosopher has thrown doubt upon the concept of there being 'facts', that it is still a controversial philosophical issue. From the perspective of occupational discourse, that there is a 'factual' basis to action can hardly be doubted and hence, courses should cover these 'facts'. It is too often a short step from accepting basic facts to saying, this is the way things are and this is the way they should remain. The double-bind that this represents is that if there is such a 'factual' base line then it becomes very hard to argue for change from a position of invoking 'facts', because typically such arguments are contrary to base line facticity. Facts, like 'skills', are in the eye of the beholder and in particular on the stage an individual has reached in being able to reflect upon experience:

> *I found that the mentors tend to take a lot away from you and you're pushing all the time to get, to do more, but I think you're more concerned at the end of the day to gain more practical skills rather than, you know, the different psychological and social sorts of skills, I think a lot of us were thinking, "Ooh I haven't done an injection, I haven't catheterised anybody." At the time you think that's important, you don't really realise until you've qualified what's important.*

This experience of needing more time to practice certain skills was echoed by a senior clinical manager who teaches on the same programmes:

> *Some development of clinical skills needed. I think they need more foundation in a lot of the regular things, a lot of them still get very anxious about doing injections, perhaps doing blood pressures, that sort of thing, because of some of them, say if they work on a care of the elderly ward, they might not need to give an injection or do many blood pressures and them perhaps they work in the community and then they might work on a chronic disability or rehab ward, and so they might not have done it very much in the whole of their training, so I think those sorts of things perhaps they need to be more conversant in, just so that they feel more comfortable. But a lot of them pick it up very quickly anyway.*
>
> *...even though they say you do enough clinical hours and the modules, it's not enough because the confidence would grow on one placement, it would have eight shifts or something. You would get there, it takes a while to get used to the ward, and you're just starting to get used to it and then you're off again and your confidence goes right down. And you don't really have time to develop new skills that you get from each ward, and it doesn't really all come together. You're picking up as the course goes along but it's not, you know, it doesn't gel really until the final term and that's only like, because we have a bit more responsibility.*

Time is clearly an important factor. It has a material chronological dimension measured as clock time. Clearly this has to be long enough for particular events to occur: doing blood pressures, injections and so on. However, how and when this should occur may still be debated. Should it occur as a vital, foundational element of courses given that 'a lot of them pick it up very quickly anyway'? What is it that is vital for a course to do? These are not issues simple to resolve. However, some insight can be gained by continuing to look at graduates reflections on these matters:

> *I mean although I have never done haematology before, there's a lot of things that I'm doing now that I can relate back to things I've learnt at college. For example with working at the oncology hospital, obviously there was a lot of chemotherapy, and on haematology wards you get an awful lot of leukaemias having chemotherapy. So even if it is just a fact or recognising the names of drugs, I feel I have got a knowledge base to work on that obviously I've picked up through my training. And the theory side, the things we learnt in college, they're coming out all the time really. We're using them sometimes without even realising, but even just sitting*

> *down and talking to someone. And I think also when people ask you questions, and if you know the answers, which, very often you don't but sometimes you do because you've learnt it at college, it's nice to be able to pass on your knowledge to patients that are enquiring. But yeah, I think it's been a good basis for being qualified.*

The basis that begins to emerge in passages like this is that a broad framework of ideas and theories has been given which provide reference points. It is a process that can be likened to a backward glance on something that at first seemed insignificant, irrelevant, or unassimilable that later takes on significance. Rather than skills and 'facts' for immediate use, it is a framework for making sense of things to come in the future, for creating a sense of a greater whole:

> *... s a nurse, as I was saying, I think it's underpinned what I've done since, and I still look back to my notes and I think, "Oh yes" and just sort of like the, the enquiry and the ability to utilise the library and critically appraise an article and I think that definitely does set you apart.*

What a graduate is expected to know and be able to do at the end of a period of study has shifted, or is in the process of shifting from the detailed acquisition of 'facts', 'ways of doing things', and skills to a broader framework of understandings from which to develop further:

> *But certainly all the more intricate skills I don't think they need to be conversant in before they qualify, and we try and stress to them in whatever area they specialise in, once hey have qualified they will learn all the skills that they need to there. So if it happened to be that they are working on a ward that is abdominal surgery, then they will learn about drains and God knows what there. They don't need to have learnt a tremendous amount in their training.*

> *At the moment midwifery is moving so quickly (...) if you want to stay in and extend your role and do everything then we are fortunate here in that they do allow us to do that.*

Without a broad framework of understandings generated through the undergraduate programme, graduates are left to figure out 'the picture' for themselves.

12.4 Qualities of graduates

It is typically through expectations being challenged in some way, or in noticing some difference in relation to other professionals qualified through different routes that the qualities of graduates come to be identified. Data extracts in the previous section have begun to articulate qualities of graduate practitioners perceived by employers and colleagues, including interpersonal, therapeutic and caring skills, and high quality of psychological care. Flexibility is often noted too:

> *...the non-graduate D grade (...), newly-qualified takes much longer to slip into things. I think it's not them (graduates) knowing necessarily any more or being able*

> *to do any more, it's just their frame of mind, they have learnt to be adaptable and flexible I think... and a bit more self-reliant, but from a management point of view, you know, it's been a really successful appointment.*

This in the view of a senior nurse manager seems to be combined with an ability to take on responsibilities quicker:

> *I often get (...) feedback about new qualifiers...because I suppose on the network within our mental health service and my past background, the current service managers will often say, "Do you know so and so? What are they like? What are their skills? Would they be good working for me?" So I still do get to now about new qualifiers...and at the point where they qualify(...) one of the benefits seems to be that they can acclimatise to...the acceptance of higher levels of responsibility a bit quicker (...) they get I think significantly more direct contact with patients through the course and that in many ways gives them more confidence to take on the role of the qualified nurse.*

A midwifery manager focuses on the broader perspective of graduates and points to the role that they can take in challenging routines:

> *I think a degree gives a lot of things. I think as far as the profession is concerned the academic err, stability that previous courses haven't, certainly certificate course and diploma courses. It also gives you a breadth of knowledge and an insight into a lot of areas that probably would not have been studied before. I think perhaps the problem with midwifery, as with nursing and with other areas of work, people tend to be very tunnel vision and you know, you learned by rote and that is the way the profession has floundered. "You do this because. We have always done it this way," instead of saying what we want at the end of the day is a live baby and a well woman – how you get there is totally irrespective, you know, if you want to swing from the chandeliers and there is no research to say that is going to be contrary to it, then that is fine, let her swing from the chandeliers. But somebody wants to do something that you feel is detrimental, then at least you are educated enough to explain that. Other professions, i.e. the medical profession has had a strong power base, in knowledge, and that knowledge is power and midwives and nurses have never had that.*

Graduate midwives from pre-registration routes were reported as providing fresh perspectives which empowered women. One midwife, who was a mentor to undergraduates during their clinical placements now works alongside graduate practitioners as a colleague, gave the following view:

> *They're very assertive midwives, they're excellent women's advocates. That's something that we, coming from a nursing background, we're not very good at, and we are taking quite a long time to catch up. They are very research orientated, and they're good change agents.*

A sound knowledge of, and often experience in, research skills and enquiring approaches to practice were identified as key strengths of the graduates completing the programmes.

Comments from undergraduates and their employers identified graduate practitioners as valuable resources:

> *I applied initially to go on the bank there because it was quite near my home (...) and when they found out I was a degree nurse, they used that information really, they'd got a project to be done and there wasn't anyone really available to do it at the time so they asked me if I would be interested. And I thought it would be interesting and it sort of fitted in quite well with the bank work as well.*
>
> *I wanted to be involved, I asked to be involved in writing the guidelines and standards, and I did initially write one for care of a woman with an epidural in situ.*
>
> *...at the sisters meetings for example, if anything like this comes up our sister says now, "Oh yes, we've got the nurse who knows about research (...) the polytechnic nurse, she can do it, she'll do it," So yes, that's another example of how it's sort of recognising that I'm able to do other things than the sort of practical skills of the RGN course.*
>
> *...one thing I think they all picked up on, I mean obviously when they interviewed me they had my application form with them, they all wanted to know about my research project. And every one of them sort of picked up on it, and I think that probably went for me, because I was interested in what I'd done and I was able to talk to them.*

Enthusiasm for, and depth of knowledge of, research was identified by one senior nurse manager as a key feature of locally trained graduates; graduate practitioners were valuable assets within the questioning, innovative cultures of care which the manager was attempting to promote:

> *...I think their appreciation of research is often better formed...I mean I've put a paper together for this organisation to commission some research (...) and I've talked to the University about that and within two days of me talking to the university three people have rung me up and were already qualified through the degree programme saying, "I hear you want some research done." I haven't even got the money at this stage but people are putting forward themselves very positively saying, "This is a really interesting piece of work, I'd really like to do the research for you." Umm...and when you talk to them about research they come up with methodologies, you know, you can talk about different methods. I mean we, we've been sort of using grounded theory on this earlier work and I said that to the nurses and was really, extremely surprised and very happy to hear someone saying, "Oh I know what grounded theory is" and could debate it's merit or not (slight laugh) as the case may be. And I've not had that through Project 2000 nurses who don't maybe have that, that same level of sophistication, so there are differences in the course.*

Research skills were also of value in day to day care, promoting client advocacy:

> *...I think it gives them a breadth of experience and knowledge that they won't otherwise have and a bargaining power. Again, certainly now we are becoming more research conscious and in order to put your point across in order to be the woman's advocate you have to be able to present research and you have got to understand it. And research that is meaningful. (...) It is difficult when you take someone who has not had a basic education, who has come through the general route of nurse training and the certificate or even the diploma route, to then go on and say to that you need to have, and teach anybody about research (...) unless that has been ingrained into them as a philosophy throughout their professional life they tend not to use it.*

Skills and experience gained during undergraduate programmes were particularly valuable when graduates subsequently practised in the locality where they trained. Experience of the educational approaches, assessment and mentoring were particularly useful as graduates gained experience and took on greater roles of student facilitation:

> *And I mean I've used them quite extensively, and even the E grade, I used her for a post basic course, for a diploma course as a mentor and she did a good job every time. They obviously have that edge of understanding, you know, the structure and learning contract work, and reflections…*

12.5 Transition to the role of staff nurse or midwife

Successfully negotiating the experience of transition has already been discussed in relationship to confidence and expectations of self and colleagues[4]. Given its importance a more detailed exploration of the experience is justified. The transition process for each individual graduate is unique. It is however possible to indicate common themes emerging from the data which have implications for the education of students and the support, continued education and development of newly qualified staff.

Being a student on an educational programme provides a sense of structure which can give way to a period of great uncertainty as it nears completion; it is replaced by the worries of finding a job, settling into a new role and so on. Stress can occur at many points along the way. Some newly qualified graduate practitioners may not feel ready but know they have to take the plunge, while others feel that the time it ripe to move on in order to further their professional development and learning.

Anticipating the experience of the new role is perhaps not something that can actually be fully prepared for. It can only be experienced when it happens. Different people, as usual, will respond in different ways:

> *I don't think I could really have anticipated really what the working was going to be like, but it's a lot more administrative than I thought it would be, I mean – and I remember people saying, "Make the most of being a student," like spending more time with patients and sitting and chatting and like now, I mean I'm just amazed at*

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[4] As a preparation for the world of employment, the principle of 'making judgement consequential' is clearly relevant - see Chapter 14, principle 7.2.

> *how, the lack of time I am able to spend with patients sometimes. I couldn't anticipate that really, that was quite hard.*
>
> *And I mean there's been occasions when we haven't had beds here and in fact we've arranged to get them sent off to the Infirmary and then getting an ambulance is the most impossible thing in the world. Things like that as a student just somebody else saw to. You know, you knew that they were going on, but you didn't know what they were getting in a fuss about. So now you realise why they were getting in a fuss because it does sort of get you wound up, little bits and pieces of things. Sorting out things from pharmacy, making sure that everything's wrote up and the scripts are done for when the doctors leave at five o'clock. (...) you do get a lot of hands-on care with the patients but it's surprising how, how much less contact you have going from student to qualified. I didn't expect, I always thought I would be the type of person who would always be like hands-on and never sort of getting shut in the office. But I mean there's plenty of times when this computer work has to be done and somebody else will have to bed-bath the patient, which I hate myself for, you know, but then I suppose it has to be done really. I couldn't leave the auxiliary to do the computer work so they have to be the one who baths the patient really, which I didn't really expect.*
>
> *The wards are quite short staffed, and you really did feel as if you were being thrown in at the deep end, whereas (...) if you are in the labour ward they can only allocate you to so many people, and you can only do so much at the one time. So it's a bit more relaxed on the labour ward, even though it can be more hectic!*

Responses to new responsibilities of practice as a registered nurse or midwife provide another range of contrasting experiences:

> *I think I didn't realise how much more enjoyable it would be to be a staff nurse than it was to be a student. If you see what I mean. (...) It's just you're given a lot more responsibility. So everyday you come on your shift you know exactly what you're going to do and you know what you have to get done and you can set yourself a little plan and get it all done. Whereas when you're a student you're basically just doing what you're told to do or following other staff nurses and watching what they're doing. So you don't get any, I don't know, it's not a challenge at all. (...) So it is more, it's a lot more rewarding that I thought it would be. I think. Once you get over the first month or so when you just do everything wrong of course.!*
>
> *...play acting on the wards really and then suddenly full responsibility and I think you've just got to learn then and you've just got to accept it when things go wrong and it's your fault. I've had like awful things, I've brought like six patients in four beds that weren't there and they've had to go home again, messed up a good few things. You don't do it again.*
>
> *...I think I graduated feeling very under confident and lacking in competence as well, And when I try and think up why that was, I think perhaps it was being aware of responsibility, the reality shock of being, you know, having a case load of patients and it was my responsibility and that I was accountable for the care that I gave*

> *them. Umm, but I think also perhaps we were so supported and wrapped in cotton wool as students that we'd never really had that much responsibility. Umm, you know, we were always supernumerary so though in our management placement we were encouraged to take on a case load that was equivalent to a staff nurse, we didn't really because we were still extra numbers.*

The theme is reiterated over and over at length. There is something of a 'reality shock'. It always comes as a surprise – sometimes pleasant, sometimes not. Why?

Now a professional, the individual is part of a team in a way that the student is not. Student status typically provides little continuity and a 'Cooks Tour' of clinical experience. One practitioner describes the temporary status of students in her clinical areas which leads to a sense of impermanence:

> *I mean my second year students do ten shifts in four weeks – it's not much, and then they move on and then you get another lot come in. So it's a bit conveyor belt-ish…and the relationship. And it's interesting because certainly one of the fourth years commented that when you are in your last module is the only time really that people ask you what you did on your day off, whereas you know what I mean, in the sense that you are not part of the team the same. Which is a shame really.*

Being part of a team has its disadvantages, and one student describes her unhappy discovery of the 'backstabbing' and personal striving which dominates the working environment in which she finds herself as a 'full' member:

> *I still love the work, I still really, really love the work but what I don't like is, and I never expected because I've never been on a ward for anything more than two months, I've never got into or been involved in any of the infighting, the backstabbing and the political nastiness, and I just, I just never knew it existed to that extent and that's what shocked me really (…) so much sort of naked ambition that people are prepared to tread on whoever they can.*

Full time shift work is physically demanding for graduates who feel that the fragmented nature of their clinical experience as students has not prepared them for the realities of the job:

> *(As a student) I think probably six shifts on the trot would be the most anyone ever did. Umm, which isn't very realistic when you come to do a ten day stretch! (laughs) As soon as I started working full time fours – zonk! (laughs) I was really poorly, I just couldn't cope with it. Totally different.*

However the transition is accomplished, it happens. A flavour of employers responses to a questionnaire distributed by one institution is given in the following data extracts. They are responses to a question of how effectively nursing graduates made the transition to staff nurse roles, integrating and contributing to the work of nursing teams:

> *The three graduates from last year who are employed on my ward have settled in extremely quickly. They show great individuality with strong ideas based on well*

> *defined personal philosophies of nursing. They are keen to develop and, once established, I am sure they will have dynamic careers. They are constructive and questioning, supportive, and above all, highly motivated. My only criticism is the inherent need to 'cope' with all situations and hide the stress they are suffering, as is inevitable on the transition from student to staff nurse, especially on a frantically busy acute clinical area.*

> *During recruitment for D grade staff nurses in the summer, I received several applications from graduates of the nursing degree. I was impressed by the quality of these applications in comparison with our usual standard. The graduates were able to articulate their personal philosophy of nursing, demonstrate self awareness of their strengths and limitations and showed a real enthusiasm for nursing. I appointed two graduates and these have now demonstrated these attributes in practice. They are both very thoughtful about practice, they have a client centred approach and work well within a team. They are also very eager to continue to learn in practice and have faced up to their limitations with a commitment to continue to build up their knowledge and skills. I think the most difficult thing they have found is to reconcile their ideals with the reality of a 'normal' workload on this busy acute ward. Both graduates have learned (sometimes rather painfully) that they need to develop skills of prioritising work, organising themselves and becoming more proactive rather than reactive. After three months this was still a problem, but after six months they feel pleased that they are now coping well. I wonder if this is normal of all graduates or particular to those from the Citytown course?*

12.6 The care environments where graduates work

Graduates qualifying during the period of this research have entered the professions at a time of great change. The climates pervading clinical areas set the context to their development as professionals. As an illustration, one manger of a specialist regional unit related the positive effects of an increase in productivity relating to major specialist treatment on nursing care of all patients in the unit:

> *... it's been quite difficult to manage that, because our physical size has not altered and the number of patients has actually increased as has their acuity, but it's meant that we've generated more income, so the staff have been very tolerant of that .(...) I managed to negotiate that we would put three nurses on night shift for example whereas before there were only two. (....) That has been a very positive spin off because clearly three nurses on night shift improved the quality of care of all the patients on the ward, not just the two or three (...patients undergoing specialist treatment) at that time.*

At the other extreme, work climates at other locations were described as follows:

> *I'd say that it gets that acute and that bad that you can't cope and it's unsafe probably, well I can think of three times in seven months, so it's not a real, real rarity, but the main time I can think of it was totally the Trusts' fault because they decided that no surgical admissions would go through casualty, they would do*

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> *straight to their respective ward. So we had 17 acute admissions within, I think it was about an hour. (…) Obviously a lot of these admissions were your usual GP, you know, the patient has got constipation, but that doesn't detract from the fact that a lot of them are seriously ill. So I think that lasted about a week and they realised that they'd made a mistake trying to save money you know, by not putting them through casualty, and that it was really unsafe.*
>
> *It's a very, very busy ward, it's like notorious in the hospital for being absolute bedlam so we always had more staff than other wards, but it never seemed quite enough, but it certainly seemed a bit better than it is now.*

Given pressured climates it is not surprising that many graduates report periods of role related stress. Despite this, reflections upon their career are positive, and graduate motivation is high during these early stages of a career in practice:

> *…I don't like the thought of breaking my contract because its stressful, you know, I see that as an admission of failure, and I don't like that so I'm sticking it out.*

However energy and commitment are not infinitely elastic. Issues of pay and responsibility in general, and the 1995 pay dispute in particular, revealed another level of frustration:

A course could be said to be successful according to the extent to which graduates have internalised its values and attempt to use them in their everyday practice:

> *The whole ethos of the course as it emphasised the normal has definitely got to be the most positive thing that stands out for me. (…) That is still my philosophy and if I have got a future in midwifery then I still see myself going along those lines (…) staying well away from the medical model in that, anticipate normal events, anticipate normal healthy pregnancy, normal healthy woman and child, and also a satisfying psychological experience.*
>
> *I think we all finished the course with a certain philosophy of nursing, which is very individualised and quite therapeutic. And I think that was ingrained into us from a very early stage and if I was to say, you know, the strongest part of the course, that would be it.*

The question is, can such values survive practice?

With the acceptance of a 'lowering of standards' from the ideal to take into account practical circumstances, a split begins to occur between theory and practice as well as between ideal values and practice:

> *I feel that I may be starting to slip into this things that, "Well that's great but it doesn't actually work in practice" you know, that I am really able to see that is happening. Umm… I mean you do, you try, but I think as you're day to day on there then you realise that certain things, I mean you are not able to do and you remember back to sort of thinking about…well just such as explaining everything*

> *you are doing to patients, and I used to think that was so important as a student, I mean I still think it's very important, but as a student I was really able to spend time doing things, maybe I could go round and explain what staff nurses were doing as well, or what was happening with their care. But now I find that I'm that busy trying to arrange things, arrange what's happening and sort out this and that I'm not actually telling the patients all the time what's happening to them. And so maybe, I mean that's one example of the ideal that I would like and not actually in practice. But I mean some days maybe you would have opportunity to, but it's just some days when it gets a bit busy then you are not able to.*

Holistic care and the ethic of building human relationships with clients are common to the undergraduate courses. The value of talking with clients is clear to graduates, however:

> *I know there's no such thing as a routine patient but our routine things like varicose veins and stuff I think do get good care, but umm, the week before last there was a crisis in the hospital with medical beds and we'd actually had loads of (empty) beds over the holiday period and we ended up taking in all these medical patients and emergencies and things. And I was on a late shift, and I know that, I mean there was a particular person who came in and they'd been fit and well in the morning, (…) developed chest pain et cetera, et cetera and were brought in in an ambulance and actually had an aneurysm, an aortic aneurysm of about ten centimetres that was leaking and so they were obviously going to die, and nobody had bothered to tell them that…so I had to sit down and tell them that they were going to die. And at the same time I had about four admissions, medical admissions, you know things that (…) take much longer to cope with when you're not used to them. And I just had to leave this person basically, to get used to the idea that they were going to die… and went home feeling awful and I came back in the morning and they had already died. (…) And I did write a critical incident report, because we have those on our ward, we have umm, it's all sort of set up for us to be able to do that if we want, but I just felt really awful and I just feel that sometimes, it is dreadful.*

Conflicts are commonly reported by undergraduates between prioritisation of scarce resources and maintaining personal philosophies and ideals of practice:

> *I think sometimes, umm people think that we're a little bit odd from the so-called new courses because we want to do things like, you know, sit with somebody if they are on their own and they are dying, and umm, I think they think we've got our priorities a little bit wrong… and you know, I'm sure we have, and you know quite often you can't sit with these people 'cos you're too busy elsewhere, but, you know, you should be able to. Which is… I think we keep maintaining whereas they just think you can't and carry on with things. So I think (pause) I mean we used to be told things in college like, "Somebody should never die on their own, 'cos that's just not acceptable and blah-di-blah-di-blah," but in the real world you just haven't got time to sit there and it's no good saying that, you know, you should do, but you can't, you just can't…*

Compromising values in the 'real world' becomes a 'fact of life' in a new role:

> *I think we would put it into practice as a student. Umm because I always used to look at communication and think, "Why aren't those nurses talking to those patients? The patients look so scared, so anxious." (…) I really didn't understand the constraints of the short staffing or you know, prioritising because we were given one or two patients and I felt like I could give them everything. And you know the patients used to comment, "Oh it's so nice to have you because you sit and talk to me." And I thought, "This is what I'm going to do when I'm a staff nurse!" (laughs) "I'm going to sit and talk all day." And it was difficult I think not to do that. And people did comment to begin with on my time management and I think that probably was my biggest weakness, err, because I wanted to give people everything, and umm, I'd be there until five or six o'clock after an early shift.*
>
> *I think that aim was give really high standards of therapeutic care to be honest with you. But umm, it's really difficult because of the staffing levels. Umm, I don't feel extremely frustrated that I'm not able to give, I think I've got quite high standards of care and I don't feel extremely frustrated that I can't give them, you have to prioritise. And umm, sometimes you just have to realise that you can't always give everyone what you want to give them. But I think everyone on the whole has a really high standard of care and we all try to maintain that. There isn't anyone that I would think, "I wouldn't like her looking after me." I think when I was there as a student most people, I saw them as my role models I think.*

Good communication can so easily be perceived as bad time management.

12.7 Opportunities for continuing professional develpment

The newly qualified graduates' abilities to continue learning are clearly important. No course provides all that is needed. Reading is thus one natural first source reported by graduates:

> *Initially my head was in book all the time and I think too much, because I was just like, you know if I looked after someone right, "I need to know all about this by tomorrow, I need to have a direct understanding of it." Umm, but yes, my knowledge has increased because there are a lot of nurses on the ward, (who have) a lot of knowledge in certain specialities and they're quite happy to share that. So that's good and I think I've learnt a lot from them. (…) And I've also tapped into a lot of knowledge from doctors and from sort of physios and occupational therapists as well and I think that's really helped.*

The resources of a learning environment are principally the people within it. A good learning environment is characterised by a concern to welcome newcomers and assist their development and learning in new roles:

> *…they have been so welcoming and they know it's difficult, a difficult area to work in, but because they've made it so, not like an easy introduction, but they've almost broken me in very gently to get into it and it has really made a difference.*

One graduate who moved location to practice on a specialist nursing unit described a four week supernumerary induction period, getting to know the hospital and the unit, followed by a three month period of preceptorship:

> *I mean when I got there they gave me an enormous folder, absolutely full of information on, not only on the first four weeks, but also how the preceptorship runs. I don't know whether it's throughout the hospital or whether it's just because of the ward I'm on, the staff on it are very oriented to new staff. I think because it's quite a stressful ward it's very, very busy, I think it's probably their only way of making me really settle in. If they didn't do that I don't think people would stay there. It's very fast and I would say it is very specialised.*

Less formal opportunities are of course also needed. Simply watching the practice of others in order to increase one's understanding and experience is critical:

> *I've been able to watch a lot of...because obviously before you do IVs you watch a lot of them being given. I've always had somebody with me as I have done the drugs, someone has checked them. I have watched a lot of IVs being given. (...) There is the basic nursing care there, but there is also, I mean the nurses take bloods, they canulate, do IVs and all things like that. So although I've not been doing them I've been given a lot of opportunity to watch others do them.*

The good learning environment is characterised by high morale, motivation and mutual education:

> *Yes, it's really good, yeah, everyone's really good to work with, quite motivated. They're quite young really, like the sister is quite young and she's motivated. I think it's got good teaching opportunities, to teach students and we also get like, good teaching sessions we give each other. We each do a project each month (...) it's quite good because it keeps you going and thinking and sort of like opportunities, because I want to do a pain booklet for patients and they're really supportive and encouraging of anything like that if you want to do it.*

Too often education has been seen as an add-on with the typical split between learning for students and learning for staff.

Applying research to practice has been a key theme in undergraduate courses. Again, where reflexive enquiry is part of the culture of the clinical area, graduates find no problem in applying the approach:

> *...all the nurses that are on the ward are very research based. (...) they always want to do well. It's a very high powered there, you know what I mean? And they are all very young, very dynamic nurses and there's lots of room for movement and improvement, which they are always very geared into. There's none of this, "Oh we've always done it like that so we'll do it like that." They are always open to new ideas, and I think that's because it is a speciality and there is no room for old fashioned ways. They are always moving and changing.*

At the other extreme graduates can find it very difficult to keep up their motivation:

> *...it's difficult to really keep up the enthusiasm and when you're in a setting where the standards maybe lower than you would like, it does eventually have an effect on you. And you just get a bit, get a bit swept along with it really, so although initially you like to make sure you know the reasons behind doing things and stuff, when nobody else is bothered, and there's nurses that have been there for ages and they don't know, you just think, "Oh flipping heck," you know, "what's the point of all this?" And it's quite, it does damage morale really because when you're so (...) I've not had the time to sit down and talk to patients all that much ,quite a lot, umm other times if I have been talking to patients I haven't got the background knowledge, enough background knowledge of their condition to really feel comfortable you know talking to them about, because although nursing it's not medicine, to be able to be of help to people psychologically I think you also need to know where they're coming from, so you obviously need to know about their condition because otherwise they just don't see the point in, they want sort of both really, they want somebody to sit and talk to them but if you haven't got a clue what's wrong with them then there's a limited use really, I think. So it's like all I can say I feel sometimes I just haven't had time to get to know the patients properly and be approachable for them to actually feel they can ask me things. Then the other side of it is that because I'm not really learning an awful lot about the conditions and things, if they were to sit down and ask, talk to me and ask me things then half the time I wouldn't know anyway. And the environment research that if I wasn't to know and I was to go and try and find out I'd be like, it'd be almost like well why do you want to know? Just tell them they have to ask the doctor, (laughs)*

Where research is not a natural part of the culture, then if graduates do not want to compromise, they are placed into the position of being change agents.

Looking to make significant change when you are still in a junior position is not realistic unless there is a democratic culture of debate. Change may often mean being critical of the work of those who are in authority:

> *...and how do you tell a senior sister who you are working with that you don't like her practice? So for me I have compromised quite a lot of the time. Then when I have done it on my own I have done it my way, and found that I have combined a whole lot of different factors and used then in a way that I have found most effective and acceptable.*

Or it may mean challenging, and being challenged by, personal practice and the practice actions of others:

> *They are very keen on monitoring,*[5] *and I am not. Umm, and I do find that a lot of the time, if I go away for a meal break for instance a normal spontaneous delivery is monitored when I come back in the room. (...) I actually attended quite recently a*

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[5] The graduate midwife is referring to continuous electronic monitoring of the foetal heart during labour. This is a contentious, contemporary issue in midwifery practice (see Sleep – report in progress).

> *foetal monitoring study day which was very good, and I was, and I can see its purpose, I do feel it has a purpose, but I feel it has got to be very selective (…) they see me take the monitor off as soon as I come back in the room and I think some, some midwives, not all, but some of them are judging me as different, because of my subtle ways of practice let's say.*

Or, it may mean choosing a different working culture which accords with personal choice for professional practice:

> *So the choice for me was to really go into independent practice.*[6] *That was the only place that I could see the sort of midwifery that I really wanted to practice being practised.*

However, if there is a culture that sustains a learning environment for professional practice, then change may be more realistic.

Making changes may seem slow and fraught with difficulty. However, the graduate when embedded in the system begins to experience the fact that they will be the guides to students of their own:

> *…I'm just having my first student tonight (laughs), and thinking, "How am I going to reflect with her?" Umm, but now I reflect quite informally I think. And I do make an effort if there's been a very acute situation to actually get everyone together afterwards and say, you know, "Is everyone happy with that? Does anyone want to off load?" And people laugh at me and say, "Oh there she goes again!" But I think that's quite important if there's an acute situation, that nobody goes home with bad feelings.*

It may be a small start. But it is a start. In time, a critical mass of practitioners may enable processes of change to snowball:

> *What you need is a critical mass in one area, and that's the problem. (...) I would like to think one of my targets is that within five years (...) we will certainly have 50% graduate practitioners.*

Graduates undertake formal and informal roles relating to student teaching and mentoring. Some graduates are happy to take on the role when it feels right and is at the right time, whereas for others, it is imposed and they do not feel ready:

> *I had been qualified two days and I had to mentor a student (…) a nurse, and I thought, 'I don't know where everything is on the ward.' (…) You just look on the off duty and there is a little blob there near your name and one near theirs and you think, oh, you're going to be a mentor! (…) I asked to go on a mentor study course which was two days and I went to a mentor update, I went to anything that was on mentors at the time. It doesn't prepare you really for passing on your knowledge, where you feel your knowledge base is a bit…you know, you are treading carefully*

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[6] Unlike nurses, midwives are able to undertake independent practice.

> *yourself (...) and it is difficult for the student, she may think, 'Gosh, she does not know what she's doing,' and it must look terrible.*
>
> *(I mentor) only the first and second year students, I don't personally feel as if I have got enough experience myself to mentor a third year student, I feel it would be unfair on them really*

It is important to recognise that graduates need to move at their own pace in moving towards becoming key change agents.

12.8 Support and preceptorship for newly qualified graduates

A learning environment needs to be able to support the professional development of staff at all stages in their careers. There is, of course a particular need for support for the newly qualified, irrespective of the type of training route undertaken by the practitioner. This is recognised by the UKCC's policy position on preceptorship, which has been revised and clarified (UKCC 1993; UKCC 1994; UKCC 1995). The Council has advocated the concept of clinical supervision throughout the clinical careers of nurses, midwives and health visitors, with a period of preceptorship acting as a fundamental base from which practitioners commence their careers.

The Council acknowledges the major transition from student to professional, noting that this can be a challenging and stressful period (UKCC 1995). Whilst being professionally competent and accountable, newly qualified practitioners require support as they take on greater responsibility within their role:

> *"The Council considers that, as good practice, all newly qualified registered nurses, midwives and health visitors should be provided with a period of support, where possible under the guidance of a preceptor, for approximately the first four months of registered practice."*
> (UKCC 1995: 1)

From the accounts of graduates in the TYDE project, there is to date considerable variation concerning the extent to which such good practice has been adopted. Not all Trusts have established programmes for preparing preceptors for their role and structures for preceptorship; some are in early implementation, and yet others have matured significantly and provide newly qualified staff with effective support:

> *They have a preceptor for three to six months depending on what they want, and they set specific goal with the preceptor and then we have certain things that are about orienting to the speciality, to the ward in general and really self-directed as to what they want to be doing. But they have a preceptor as I say, and they continue that relationship as long as they want.*
>
> *...we feel as though we are doing reasonably well with the preceptorship throughout the Trust. We do have a vague preceptorship policy and we're very firm in ensuring that the newly qualified nurse and midwives are well preceptored. We've had*

> *courses for the training staff to help them through (…) we ensure that we've got preceptorship for temporary staff, part time staff, bank staff and we say that we won't employ any agency staff unless they have been through a preceptorship series. So, umm we feel as if we've got the basis of a very good way of looking after preceptorship*

> *I remember asking in my interview, I said, I asked about preceptorship and she said, 'Oh we don't have that,' in some dismissive way. 'You don't need someone to hold you hand,' or something like that. Everyone has been very supportive but I was not assigned to a particular member of staff.*

The needs of individual newly qualified members of staff do vary. Some may not need a formal structure. But many implied a need for it. Unfortunately, because of pressures on staff at all levels, the execution of local policies for preceptorship has been reported as poor. Staff in most clinical areas aspire to individualistic preceptorship and support for new members of staff, but far fewer achieve the aspiration:

> *I mean I was supposed to have a preceptor which I did have, although not working with her very often I didn't have as much support as I would have liked, I was just thrown in a lot of the time and had to deal with things by myself..*

> *…I didn't feel I was being given an awful lot of support because there wasn't the time for staff to give me their experience and to give me support. (The ward sister) was sympathetic to what I was saying although it didn't really change an awful lot afterwards. I think she acknowledged what I was saying but it was difficult for her to immediately improve things.*

Once qualified, some graduates report finding it hard to ask questions for a variety of reasons; periods of poor staffing, hence there are literally few people to go and find to ask about things; a fear that they are being a nuisance, that they are expected to know, and that they expect themselves to know, 'all the answers' and to be able to 'do everything':

> *…you know I think anyone struggles with situations that they've never come across before, and I've learnt to accept that now and I don't feel so stupid about asking questions and I think that's of great benefit, having more confidence to ask. Because I felt I could when I was a student and when I graduated I felt people's expectations of me were a lot higher and that they didn't expect me to ask, they expected me to know, whereas I'm sure they didn't really.*

Graduates *need* the personal support of preceptors. It is an essential ingredient in the learning environment.

> *…I would think that support with objectives and reflection should go on for about six months. (…) I think we all felt that it took us six months to feel settled and I don't know whether that's a normal for undergraduates or for students of sort, who have trained differently to us. But we feel that it was a good six months.*

> *I think it's probably as structured as you want it to be, I think if, I mean I've had these four weeks, I feel, my confidence is, you know it's improving. I feel I've had a good induction and I feel quite ready to have a go now, to get in, and start on my own. I think if I kept saying to someone, "I'm not sure, I don't know," I think they would be much more there for me than I feel I need them at the minute. I mean someone actually said to me, it was literally, "Preceptorship is for three months but if you want a week, that's up to you. If you feel that you are coping, fine, and you know you don't need it…" they won't back out completely (…) they make you aware that they're always there if you do need them.*

12.9 Summary

Pre-registration undergraduate programmes in nursing and midwifery have demonstrated considerable achievements in the form of graduate practitioners. Attrition from the degrees programmes participating in the study has been reported as low, and graduates have achieved success at honours level within ranges comparable with other degrees within institutions.

The overwhelming majority of graduates go into clinical practice upon qualification, often choosing to consolidate within their new roles of midwife or staff nurse in localities where they practised as students. Graduates are thus perceived as employable practitioners and this is endorsed in interviews with employers and colleagues.

Skills and knowledge of research, together with an enthusiasm and ability to examine practice and attempt to implement research based change, were particularly highly valued by both employers and the graduates themselves. Flexibility of approach and well developed interpersonal skills were also highlighted. Newly qualified graduates' abilities to quickly master new skills (and in particular to develop skills within the roles of midwife or staff nurse) were praised, especially where initial perceptions of graduates' practice were that such skills required further development.

The availability and range of employment choices for newly qualified graduates appears to vary significantly geographically, and during the lifetime of the TYDE evaluation. Some graduates reported a choice of jobs, and attempted to chose clinical areas which they felt accorded with their professional and personal values, visions and practices, and where familiarity was high. Others reported limited or no choice.

The transition to the role of registered nurse or midwife, and the development of role competence and personal confidence is an experience unique to each individual practitioner; the experience of role transition is also dependent on the context in which the practitioner works. Key features of learning environments integral to working environments which facilitate the development of newly qualified graduate practitioners include:

- acknowledging the differing educational routes which undergraduates have travel in comparison with what has gone before (i.e. certificated first level programmes and post-registration – now termed pre-registration (shortened) midwifery – and revising expectations of newly qualified staff on pre-registration degree level (and diploma level) programmes;

- facilitation of practitioners' initial skills to meet specific requirements of clinical specialisms in local contexts;
- adoption of UKCC's principles of good practice for an initial period of support and preceptorship. Structures at institutional and practice unit level must support processes of preceptorship, which are oriented to the specific needs of individual practitioners;
- encouraging collective climates of learning, research, enquiry and reflection on practice, which become integral to the delivery of care, and which facilitate the development of newly qualified nurses and midwives, more experienced practitioners, and students.

PART THREE

Professional education in a degree programme

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Concluding reflections on professional education

Introduction

It may not be too far from the mark to claim that nursing and midwifery, having undergone radical reforms, are emerging from this process in a way that places them at the leading edge of developments in professional education, and in particular at degree level. It is difficult to think of other professions that have undergone such extensive reviews and evaluations. Even teacher education, which could once claim that position, is being rivalled, perhaps surpassed.

This achievement is due to the general creativity, resilience and commitment of staff in both clinical and educational institutions.

Looking back upon the data collected, and the discussion of earlier chapters, what has been learnt that may provide pointers to the development of a model of professional practice, the development of learning environments and the design and implementation of a curriculum?

A model of the learning environment emerges from the data. This model will be fully explored in this chapter. The object is to provide a focus for debate and a focus for thinking through the implications of the principles to be described in the final chapter. The learning environment is essentially a product of subjective – or more accurately inter subjective – acts through which personal and public understandings of experiences are drawn into critical and research based debate. Management is, in the ideal sense, a service to the needs of the learning environment. As such the learning environment does not make a distinction between higher education and clinical settings. Rather, these are simply different physical locations (or fields of action) within which the subjective (and inter subjective) acts generating the learning environment are performed. That this is not typically the situation has been fully described throughout the report. The question that then remains for the final chapter of this report is, what principles would need to be adopted through which the ideal model can begin to be realised in practice?

The conclusion for professionality that has emerged can be put briefly:

> *professional action finds its development, its quality, its strength in the learning environments that it generates in order to sustain critical reflection upon practice for the purposes of developing public knowledge bases through which judgement and action are informed.*

Within this formulation there is no longer any sense in making a distinction between 'care' and 'education', between 'theory' and 'practice'. Education is not an 'add-on', something to be done in the margins for students, but is essential to professional practice as the foundation of its knowledge base. Although a division of labour can be seen between HE based staff and clinical staff, this does not imply a split in the processes through which knowledge as a basis for action is created and critiqued. Rather, it focuses on professionality as being at the interface of a multiplicity of discourses and fields of social action (some professional, some academic, some political, some lay). The terms 'discourses' and 'fields of action' are employed deliberately in order to draw attention to the complex relationships between talk and action that have been central to this project. It is the nature of this complexity that defines the task to be undertaken in the design and delivery of curricular, appropriate to the generation of learning environments.

This notion of the learning environment is still uncommon and does not easily fit traditional university patterns. Arts, Sciences and the Humanities typically have a clear discipline base such as Physics, English Literature, History, Philosophy. The discipline is in a sense an end in itself, the academic pursuit of which has no need of justification by reference to its utility to the world of everyday affairs and practicality. The profession, by contrast, finds its justification in practical affairs. Unlike traditional academic disciplines, nursing and midwifery as professions[1] are seen as being comprised of several contributory 'subjects' or 'disciplines' such as physiology, psychology, sociology in addition to professional knowledge, which then have to be 'applied' in practice. The division falls into the traditional dichotomy of 'pure' and 'applied' with the latter being seen as somehow less exalted than the former. The inappropriateness of this kind of distinction within the professions has been addressed throughout the report.

Indeed, nursing and midwifery are in a position to make a major contribution to the general debate concerning professionality and the role of universities in delivering undergraduate programmes for the professions. This report is a contribution to that debate.

The key dimensions to the model are:

- contexts;
- exploration of the case: self, other and courses of action;
- the field of action and learning: transformations and the processes of learning;
- the discourses of reflection.

All of these dimensions have in various ways been addressed throughout the report. What follows is not a repetition of discussions but additions to them, a synthesis, and a reflection through which the model emerges.

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[1] Or as emergent professions.

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13.1 Contexts to action: additional themes

The chapters in this report have all contributed to exploring the particular context facing nursing and midwifery professionals and students. This section will not repeat these but will add some important themes not yet fully addressed. The first is the notion of professionality itself and the conditions under which 'the professional' emerged.

Jarvis (1983: p22) in discussing the lack of agreement on the definition of a profession, offers as a working definition that professions are *'occupations which seek in some ways both the mastery of an identifiable body of knowledge and the control of its application in practice.'* The control exercised by some professions has resulted in criticism of their power not so much to serve as to dominate, particularly the medical and legal professions (Illich 1976). Such a definition cannot be interpreted outside of the social context in which it finds it bearings. These occupations exist within a) a market place of competitors, and b) a structure of laws and customs which facilitate the power to control application. That it has the potential to dominate or to serve implies that the profession has a wider social and political function that goes beyond meeting the needs of clients. The definition of both professional and client, the delivery of care and the learning environment that results depends on the nature of the context.

Rather than attempting to do a full contextual analysis that would attempt to explore the interconnections of gender, class, ethnicity, together with explorations of patriarchy, politics and the social and economic allocation of resources, privilege and power, a much narrower sketch will be provided. This will simply introduce some directions for an analysis relevant for thinking through the nature of a professional education:

1. The rise of the professional and the market place
2. The role of Higher Education in the market place for expertise
3. The relation between academic and professional courses

13.1.1 The rise of the professional and the market place

Perkin (1989) sees professional society as having largely taken the place of nineteenth century industrial society. Its distinct feature is that professionals possess human capital (knowledge, skills, social and legal authority and so on) whereas industrialists control capital in the form of wealth-creating assets (factories, machinery, labour). According to Perkin, professional associations have increased in the UK during this century from 20 in 1900, to an extra 27 in 1918, another 46 between the world wars and by 1970 a further 46. The process of professionalisation itself accords with market practices which seek to restrict access to knowledge in order to control its 'price' through restrictions on supply. Caplow's[2] (1954) description of the process of professionalisation can be interpreted in this light. He suggested that it is necessary for occupations wanting to become professions to:

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[2] As summarised by Jarvis 1983: 25.

(i) start doing full-time that which needs doing;

(ii) establish a training school which, if not at the outset, later seeks to integrate with universities;

(iii) form a professional association which seeks:
    (a) self-conscious definition of the core tasks of the occupation;
    (b) a cosmopolitan perspective to the practice of the occupation;
    (c) to compete with neighbouring occupations in order to establish the area of exclusive competence;

(iv) seek legal support for the protection of the job territory and to publish a code of ethics to indicate the commitment of the practitioner. This results in control of licensing and certification;

(v) publish a formal code of ethics, eliminating the unqualified and reducing internal competition whilst assuring the public that the profession will serve its needs.

Nursing and midwifery were seen in the middle 1950s as semi-professions. In 1971 Etzioni still regarded nursing as a semi-professional occupation due to the inadequate length of time for training and a lack of autonomous responsibility for its decision-making. Whittington and Boore (1988: 112) following their review of the literature identified the following characteristics of professionalism:

1. Possession of a distinctive domain of knowledge and theorising relevant to practice;

2. Reference to a code of ethics and professional values emerging from the professional group and, in cases of conflict, taken to supersede the values of employers or indeed governments;

3. Control of admission to the group via the establishment, monitoring and validation of procedures for education and training;

4. Power to discipline and potentially debar members of the group who infringe against the ethical code, or whose standards of practice are unacceptable;

5. Participation in a professional sub-culture sustained by formal professional associations.

Even as recently as 1989 Hepworth refers to the fact that nursing has been considered variously as an 'emerging profession, as a semi-profession and as a skilled vocation'.

While these summary descriptions of professionalism can be criticised for omissions, they do point to important defining features of professionalisation. In particular, the contemporary history of both nursing and midwifery has accorded reasonably well with Caplow's description in 1954, particularly the recent moves into universities and the increasing claims to possess a core of defining tasks and knowledge.

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The traditional professions having long established relations with universities are law, medicine and divinity. Originally male professions, they have remained by and large essentially male professions. Both law and medicine have successfully entered the market place. Indeed, particularly in the USA, medicine has become the 'leading exemplar of a profession' starting from the foundation of the John Hopkins Medical School and attached research hospital by John Billings, which ensured scientific medicine spread throughout the country (House 1993: 20). American physicians have, as House comments, been very successful in turning their *'professional authority into very high income, extreme professional autonomy, and considerable political power.'* Thus *'while other professionals increasingly came under the control of bureaucracies and corporations, often working for the organisations, doctors became small capitalists.'* House sees this dominance as possibly coming to an end because of *'escalating health-care costs and the extension of private enterprises into the health-care business, which means that doctors will be employees of the corporation, too'.*

The market as a way of organising social practices has come to dominate government thinking in the UK since the election of the Conservative government under Prime Minister Thatcher in 1979. In reorganising the provision of health services into a purchaser/provider format with NHS Trusts and general practices being run like small to medium size businesses, the franchising of allied services and the execution of medical audits to increase efficiency, traditional patterns of vested interest and power are being eroded and transformed. This is to be expected and was intended. It has long been understood by economists that:

> *characteristic of a market economy is a tendency to incorporate every aspect of a society into the nexus of market relations. Through such "commercialisation," the market generally brings all facets of traditional society into the orbit of the price mechanism (...) everything has its price, and (...) its value is its price. As a consequence, markets have a profound destabilising impact on a society because they dissolve traditional structures and social relations.*
> (Gilpin 1987: 20)

Rather than nineteenth century traditional values and social practices what is currently being de-stabilised is the autonomy and authority of old established professions to define social and health needs. While it is not yet clear how the new patterns will settle, it is clear that the power of autonomous decision by the professional is being replaced by negotiation between purchasers and providers, the management of services to meet performance criteria established through audit and political demand. In addition, the allocation of services is less according to need (as established during the period of Post War consensus about the aims of the Welfare State) than according to the principle of scarce resources and the willingness and ability to supply and to pay which underlie the definition of the classical economics of the eighteenth and nineteenth centuries and the neo-monetarism and positive (as distinct from normative) economics of the 1980s and early 1990s.

These issues draw attention to the cultural embeddedness of professional activities. This embeddedness can either be interpreted as placing professionals into a position of passivity where they merely render services as defined by political and market agencies outside their control; or, it can be interpreted as defining the programmatic challenge for professionals. The challenge is essentially that of constructing an independent critical perspective through which are mapped the problem structures to be addressed through professional action, and approach that can only come about through habituating research within the professional culture (see Chapter 14, section 9).

The challenge is to move the professional vision beyond a limited definition of 'core tasks' of the occupation and begin to define a 'cosmopolitan perspective' that indeed transcends the horizons of immediate action and directs a critical gaze at all forms of social organisation and their cultural fields. A profession then makes a contribution to the ways in which society reflects upon itself not as a strategy for social reproduction but as a strategy for social debate, critique and development. This would make the development and dissemination of professional knowledge of central value for any society. How then do professional knowledge processes relate to the formation of centres for knowledge production?

13.1.2 The context of Higher Education in the market place for expertise

Higher education has throughout the nineteenth and twentieth centuries increasingly come to provide education for, and thus control entrance to, the professions. Just as markets distribute values, so institutions of higher education have distributed values among 'subjects'. In addition, and perhaps more importantly, they became the centres for the production of professional knowledge (Larson 1977). The effect of both is a) to restrict supply and hence influence the market value and the power of the professions; and b) to separate the processes of knowledge creation and learning from the processes of practice:

> *As professional knowledge became standardised, and professional fields became unified internally and less subject to contentious disputes among competing factions, professional knowledge separated into the theoretical and the practical. This separation meant that the practitioner learns one thing in school, often referred to as theory, and then learns to do the job on the job. In the "old days," one learned practical knowledge through apprenticeship and forgot about theory. So the split between theory and practice becomes more pronounced as a professional field develops. The field becomes more specialised as theorists focus on topics of interest and opportunity, a function of university research and academic careers.*
> (House 1993: 22)

The trend towards location in universities has accelerated over recent years as emergent professions such as nursing, midwifery, occupational therapy, physiotherapy and others have increasingly found a base within universities.

However, within the wider context this trend is not unambiguous. There is increasingly a countervailing pull away from universities as the centre of advanced knowledge production. Knowledge is capital and in a market economy the control of knowledge is a source of competitive advantage and hence power and wealth. Large business corporations and professional consultancies whether in electronics, pharmaceuticals, or the provision of information services (for example, population and social surveys, market analysis, management consultancies, media analysis and software production) are increasingly competing with universities. In short, centres of knowledge creation are becoming increasingly diffused at the same time as its transmission is restricted to the extent that knowledge capital is protected by patents and copyrights.

To restrict knowledge creation to HE institutions is thus artificial. What is being increasingly recognised is that knowledge creation is as much a product of professional action and reflection as it is of academic research. This implies that the division between university and practice area is artificial and its maintenance is damaging to the development of professional knowledge and has serious implications for the development of professional courses. The implications of this report reinforce this kind of conclusion and take it much further by arguing for the development of the learning environment as the context for professional action and the development of knowledge. The learning environment is not defined in terms of the traditional classroom. Rather, it is a field of professional action which is subjected to critical reflection for the purposes of drawing out (that is, the education of) issues for wider debate, the formulation of general principles or models, which can contribute to the formation of judgement and the development of knowledge bases. The reflective gaze can either be limited to the immediacy of situations and their problem structures; or, the gaze can expand to encompass the wider contexts within which immediate circumstances are embedded. In this latter approach, the problem structures subjected to professional attention are widened beyond the immediacy of solving a pressing problem to that of addressing the conditions under which such pressing problems occur. The task for providers of professional degree level education is to design curricula which adequately, relevantly and appropriately map the relations between immediacy and cultural embeddedness.

In distinction to traditional academic courses, professional course organisation has been characterised by a *'triangular relationship between academics, the practitioners, and the students'* (Barnett, Becher & Cork 1987). The discussions throughout this report reveal that this triangular relation has been transformed as new roles and institutions are created, as the locus of knowledge creation changes, the structures of negotiation change and the relative weight, as determined by market power, of the negotiators change. As practitioners become absorbed into market structures (albeit legally and politically regulated markets), their decision making will be increasingly influenced by considerations of demand and supply. The neat triangularity seen by Barnett, Becher and Cork thus begins to take on additional 'sides' defined by the context. Each of these 'sides' has some influence over the course, its curriculum and also influences the kinds of course experiences teaching staff, students and professionals have.

The complex of contexts described above, in addition to those described elsewhere in the report, frame and subtly influence the ways in which the self-as-professional acts towards others. The other[3] can be defined in terms of the following examples:

- client;
- colleagues within the same profession;

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[3] This can be related back to the emergent model in Chapter 4, section 4.2, and points forward to the need for a principle of dialogue in Chapter 14.

- other related professions (as in multi-agency situations);
- others as managers;
- others as representatives of 'The System' or 'Them' who are regarded as setting boundaries, constraints etc (eg, politicians, economic powers, judiciary and so on).

How does the self in relation to the other articulate this at the level of action?

13.2 Exploration of the case: self, other and courses of action

For the self as professional, the immediate, even urgent (or more often routine) demand is to focus upon the case. The case as employed here is a broader term than that typically employed by professionals. The case of the professional is of narrower focus, often defined in terms of the specific problem to which professional action is to be directed. Here, the case will be defined in terms of all the circumstances that confront professional and client as they act towards each other and in relation to significant others around them (other professionals, family, friends and so on). Knowing how to act towards the other is the object of professional education and the culmination of practical experience. However, what is actually involved in the learning and professional decision making processes is barely understood. Eraut (1985) described the situation in the mid 1980s as follows:

> *Behind the numerous policy issues, which have enlivened the debate about the appropriate form and structure for professional education, lies a remarkable ignorance about professional learning. Apart from the limited though valuable literature on professional socialisation, we know very little about what is learned during the period of initial qualification besides the content of formal examinations. Still less is known about subsequent learning, how and why professionals learn to apply, disregard or modify their initial training immediately after qualification; and to what extent continuing on-the-job or even off-the-job learning contributes to their professional maturation, updating, promotion or reorientation. Yet without such knowledge, attempts to plan or evaluate professional education are liable to be crude and misdirected.*
> (Eraut 1985:118)

Eight years later the position remains much the same. The reason for this is that academic or technical knowledge *'is capable of written codification; but practical knowledge is expressed only in practice and learned only through experience and practice.'* This may be as much to do with the different discourses that underpin each sphere of activity. While Eraut concedes that some kinds of knowledge, in principle, cannot be codifiable (particularly non-verbal knowledge), he recognises that:

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> *Performances may be written about and discussed by critics and colleagues; and there is a tradition of criticism of non-verbal activities like art and music which, perhaps overrated, is certainly not futile. The problem lies in the complex, often tenuous, relationship between comment and action.*
> (Eraut 1985: 120)

Discipline based knowledge in the sciences of physics, chemistry, biology and so on share recognisable features which are not so readily applicable in the generation of practice-based knowledge and theory. While traditionally the status has been with the science discipline form of theory and knowledge generation, professional development depends in large measure upon the latter. The contexts are radically different. Professional action is largely dependent upon the kinds of skill and knowledge the professional brings to individual cases, which in turn is based upon experience of previous cases. It is essentially, a knowledge of cases. However, a case, is itself a complex concept. Traditionally, case is defined as a 'single instance' but definitions that focus upon singularity as the defining feature are inadequate and misleading.

A single instance makes no sense unless it is either a part of a series of similars and is thus recognisable as belonging to a class that is distinct in verifiable ways from other classes of objects (this would provide the basis for a statistical approach to case study through sampling procedures); or, is structurally related to other cases and to embedding systems and processes that are both symbolic and material, which sustain and reproduce the cases and also provide the conditions for the transformation of cases (this provides the basis for a variety of 'qualitative' approaches to case study through structural, discourse, hermeneutic and semiotic forms of analysis). The defining feature of a case is thus not its 'singularity' but its mode of relatedness. It is with the concept of 'singularity' that issues of generalisation, bias and subjectivity have arisen to bedevil case study as a source of knowledge production (c.f. Simons 1980).

The formation of cases is essential to everyday practice in coming to understand the features of professional action and knowledge production. The formation of a case is a step towards rendering the complex phenomena of sensory experience 'knowable', 'ordered', and part of a greater whole of lifetime and social experience. In formulating a case some degree of generalisation and of objectivity is involved. In giving a name to a case, in categorising it as one thing rather than another, a decision has to be made as to the extent to which this case is like that case and different from some other case. As Eraut points out (1985) a kind of scanning takes place in the mind of the professional when confronted with an event to try to locate it within previous experience:

> *While most of the previous cases scanned for this purpose are likely to be the professional's own experience, some may be known only through the reporting of other people's experiences (formally in the literature or on courses, or informally via colleagues and social networks). The generalisation used may vary in both scope and explicitness; at minimum Case A is perceived as being like Case K and handled in the same sort of way; at maximum, some practical principle is consciously applied, which is thought to be valid for all cases of a certain type. Semi-conscious patterning of previous experience may also occur, making it difficult for the professional to trace the source of, or even to clearly articulate, the generalisation he is using. It*

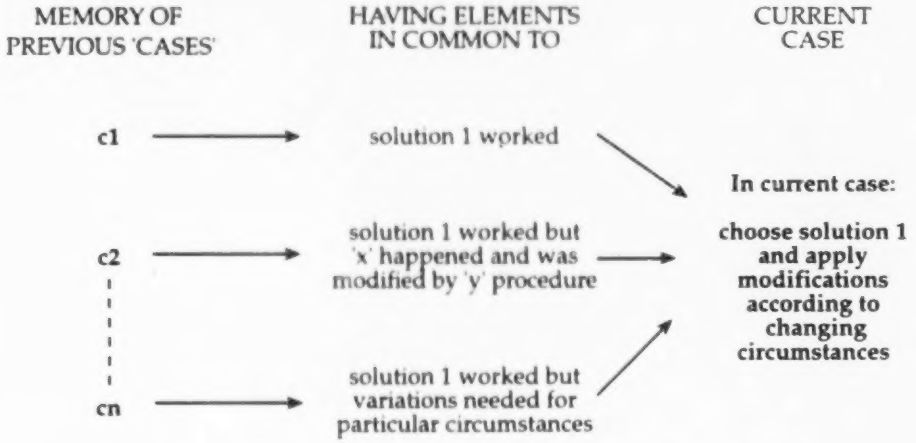
> *might be argued that one way to develop the knowledge base of a profession is to study this generalisation process, to make it more explicit so that it can be criticised and refined, and to give close attention to specifying the conditions under which any given practical principle or generalisation was held to apply. Such systematisation of practical knowledge, however, is neither part of a practitioner's role nor a popular academic pursuit; and its feasibility may be open to question.*
> (Eraut 1985: 121)

The pessimistic conclusion can in part be explored in institutional terms by asking the question: What kind of institutional structural change would there have to be to make such a pursuit attractive to both professional and academic? The question whether it is feasible to systematise practical knowledge is a different matter. This latter question is perhaps too crudely expressed for research purposes. What is at stake is not so much the systematisation of practical knowledge, but systematic research based inquiry into the processes through which practical knowledge is formed, in order to render the processes of professional generalisation itself open to systematic critique as with any other field of advanced knowledge.

Davies and Harré (1990) offer an approach to generalisation based upon case examination which is reminiscent to that offered by Eraut (1985). The difference is that it is more firmly located within discourse analysis and thus has available to it a greater range of techniques of analysis. The first step is to recognise that practice based knowledge has a narrative structure (c.f. Danto 1985). As people make sense of their experiences they employ professional discourses which are 'institutionalised uses(s) of language and language-like sign-systems' (Davies and Harré 1990). In recounting experiences, people 'position' themselves and others *'as observably and subjectively coherent participants in jointly produced story lines'*. This positioning is not a neutral act:

> *such positioning may or may not be acceptable to the person being positioned. For example, many contemporary women now reject being placed into the position of being 'home makers' within the patriarchal myth which says, 'the woman's place is in the home'. However, in rejecting such a position, they may be repositioned by many men in authority as being 'radical', 'feminist', 'lesbian', all of which may be again unacceptable to the person who is being positioned by these men. Although there is some choice in accepting or rejecting a position, the positions available are not arbitrary and may be difficult, even impossible, to avoid. Through such experiences of being positioned and of struggling against being positioned and to assert alternatives a stock of such occasions is built up. A current situation may be compared to any of a number of previous similar situations. The memory of being hauled up before the headteacher for some minor offence and being made to feel small, may in later years be evoked when made to feel small by the head of department at work. Thus a particular attribute of the two (or more situations) is drawn out and is given significance. This act of drawing out is called indexical extension by Davies and Harré. It may also be compared with the act of education which is itself an act of 'drawing out' attributes, structures, consequences and so on through processes of imagination and of reflection.*
> (Schostak 1991:54)

This process of indexical extension really describes the act of identifying similarities of structure, process or of attribute in a given event. Thus, *'the experiences of being positioned, of choosing and of making positions are fundamental curriculum materials through which knowledge of the world is developed'* (Schostak 1991:54-5). This process is extended by what Davies and Harré call *typification extension*. This can be metaphorically understood as 'a person scanning their past experience for a concrete occasion on which to build an interpretation of the position they have been assigned (whether they accept or reject it) until they encounter the record of a typified occasion such as 'nurse/patient.' Where indexical extension says that case A is similar to case B, typification extension says that the feature common to case A and B is that which is typical of all cases of a particular class of events (e.g., nurse/patient, teacher/pupil, boss/employee). While a useful distinction to make and a powerful contribution to an understanding of the way cases can build into generalisations, it is still seriously limited as the basis for producing an understanding of professional knowledge. This is made clear when discussing with professionals how they come to make a decision in a given circumstance. As Davies and Harré (1990) have described, the current case is typically assessed for its similarities with a fund of other previous cases. However, having noted a similarity, the contrasts are also noted and assessed for their importance in terms of taking a particular decision. Having decided that particular features of the current situation are sufficiently like a previous set of comparable cases, then options for possible courses of action can be identified and assessed in the light of their suitability for the current case given its particular features. The course of action chosen is then monitored to see the extent to which it leads to predicted outcomes or solutions. If there are differences from the expected, then a further search of comparisons and contrasts with previous cases is set in train and modifications made. This process of case comparison provides an account of what may be called dynamic case generalisation and can be schematised as:


MEMORY OF PREVIOUS 'CASES'
HAVING ELEMENTS IN COMMON TO
CURRENT CASE
c1
solution 1 worked
c2
solution 1 worked but 'x' happened and was modified by 'y' procedure
cn
solution 1 worked but variations needed for particular circumstances
In current case:
choose solution 1 and apply modifications according to changing circumstances

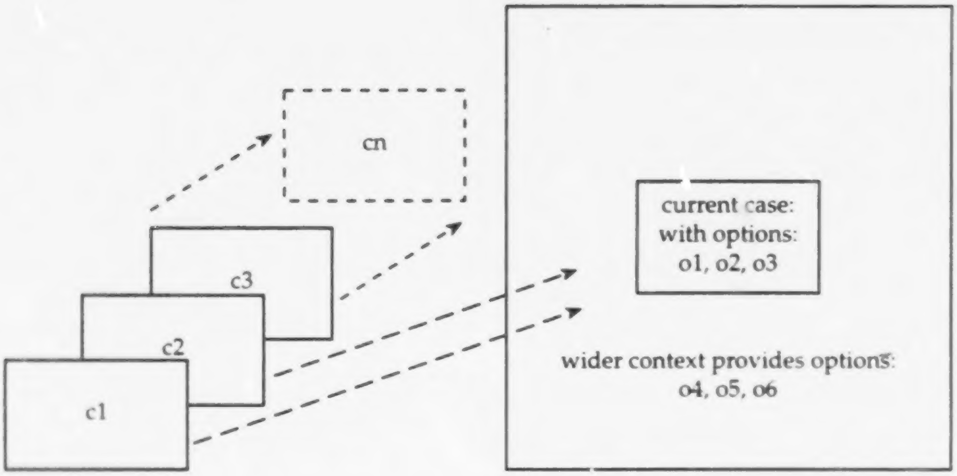
Generalising from cases

In the diagram above case 1 (c1) is identified as sharing similarities with both c2 and c3 and the current case. These similarities offer solutions s1 as associated with case 1, s2 as associated with case 2, and possibly s3 as associated with case 3 for courses of action. If the current case is more like c1 than c2, then the options most closely associated with c1 (say s1) may be chosen (than say s2 which is more closely associated with case 2). However, through monitoring, differences may be observed which lead the professional to see similarities with say c3 which may lead say to option s3.

Cases are, of course, part of a more complex context or 'whole'. This allows an alternative line of reasoning which can contribute to the subtlety of the professional's reasoning and hence processes of analysis and of generalisation. This was clearly identified by one lecturer in the TYDE project data who considered the difference between levels of practice for degree classification purposes:

> *As we all know there's a lot of difference from one student to another umm and that so often happens if we're absolutely honest, the high fliers are not often the best practitioners, (…) I mean give me a 2.2 any time you know, (laughs) umm but OK I would say yes in as much that I would expect that the ability to assess that client's health would be the same. Right? They would come to exactly the same conclusions as to umm the problems that we were looking for, were looking at. But I think the action would be different in as much that the umm the degree nurse would take it upon herself to umm look at this patient within a broader context so in other words, you know, is what is happening with this person, is this peculiar to this person or is this actually indicative of a, a bigger problem, this is just a symptom of something that's happening in this area at the moment because we haven't got this service, or there's a lack of liaison between this group and this group or whatever. And she would actually then go beyond the patient, umm she would deal with the patient and with the problems that would surround that and whatever. (…) You would expect a nurse to do that on a one to one basis and work also with the family but she would extend beyond that umm and would look to what had, things which had perhaps caused that or were exacerbating it beyond that family's ability to cope with it and would take that upon herself to deal with as a professional.*

With reference to the previous diagram, the current case is analysed equally by the graduate and non-graduate professional within its bounds as a particular instance. The difference arises in setting the specific instance in increasingly wider contexts: the context of the family, the neighbourhood, the system of community services, the structures of social and material discrimination, the context of health services, the market context and its political structures. The following diagram summarises the approach through which action may be informed in practical situations:



Previous cases recalled in terms of their similarity with each other in relation to the current situation

The current situation is analysed in terms of its comparisons and contrasts with previous cases. Options for courses of action are identified in terms of the courses of action taken with other similar cases (o1, o2, o3). However, the current case is a part of a greater whole. Through analysis of the wider context further options for courses of action are identified (o4, o5, o6). Each of these include o1, o2, o3, as possibilities but may offer more powerful forms of action.

The schema just sketched provides a framework for describing the processes through which professional knowledge is built up, not only as a personal construct, but as a public construct available for critical re-assessment. This then is the basis for a model of professional reflection, judgement, decision making and action underlying the production of publicly accessible knowledge.

13.3 Transformations: the process of learning

The challenge facing HE is to design courses which induct students into the processes of professional reflection and action. As discussed in Chapters 4 and 8 a typical approach in HE courses is to deliver contributory disciplines by discipline specialists. It is an organisational convenience but as argued in that chapter, it does not address the key problem of how subjective transformations in the organisation of information for practical purposes takes place. This is made clear by the following lecturer speaking of a colleague, a biologist:

> *… who is an exceptionally good lecturer. We are extremely lucky to have him. And he's been involved in a number of nursing courses etc. But he isn't a nurse and he in fact umm, probably would think about things in a much more medical way than a nursing way. So he's able to acquaint and help the students see what he is teaching um and relate it to the medical/health profession but perhaps not umm to nursing. Nowhere, in the second year they then start to get some, some of the science modules they get are actually taught by somebody who was previously a nurse and she is able then… because of the knowledge base they've had in the first year – it all seemed totally irrelevant or was very difficult for them to grasp as far as nursing was concerned although not as I said from the medical point of view – umm, in the second year she is able to build on that and use it to illustrate actual situations, diseases, conditions but take it from a nursing perspective. And then it all starts to make sense. But then so often, of course, they're taught something, or experience something and it's not until later that they understand why it was so relevant.*

In this passage three important themes emerge: a) time; b) the relationship between 'the discipline' and the practice; and c) the precedence of a nurse perspective in relation to the discipline perspective. The way in which time enters the educational process in this passage is interesting and will be developed further at a later point. Essentially time is educationally constructed in terms of the future anterior, that is what biology taught in the first year will have become through reflection after practice in the second year. There is an act of faith on behalf of the student, together with acts of patience and tolerance that at some future date all will become clear. This is an important structure that needs to be taken into account in both building curricula and developing teaching and learning strategies for reflective purposes. It concerns the organisation of different kinds of experience. In this instance they are dichotomised in terms of theory (as discipline) and practice (as clinical area experience).

If it is the case that theory grows out of practice and practice grows into theory, then the dichotomy between theory and practice disappears, leaving the interaction of a duality comprised of the theoretic dimension and the practical dimension. Rather than theory excluding practice and practice excluding theory, the theory-practice relationship is 'in-mixed'[4] with neither losing their identity but both only having an identity and an existence because of their necessary relationship with the other. The dynamic relation is seen as something greater than a blind application of knowledge:

> *…it's what you do with it (knowledge) that's the difference and the way which you operate with that knowledge base. So umm, you know, one profession isn't dependent on another for making decisions for it. It is actually quite autonomous. I think that is actually uh a grave difficulty for nursing and I think in that area that is something where nurses have to look and say are we a profession at the moment, will we ever be a profession because of the way in which we sit with the medical profession and the influences which the medical profession has on the nursing profession.*

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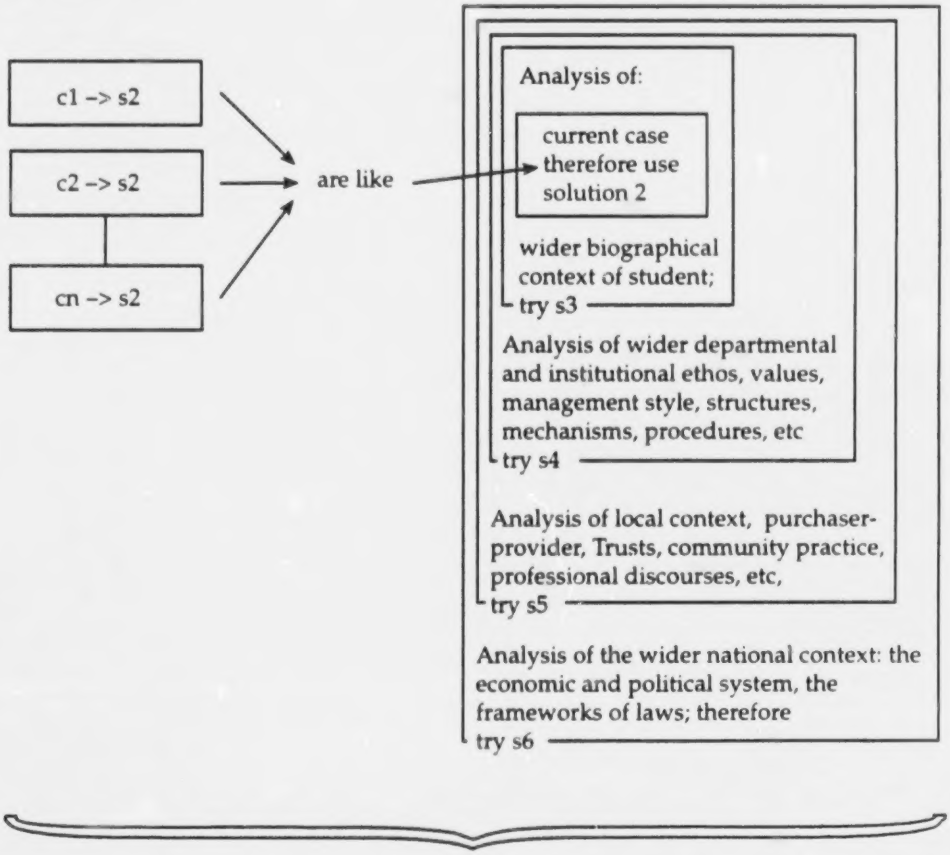
[4] It is tempting to write of an 'integration' of theory and practice and this we have done earlier in the report, at the expense of the sense of a distinctive identity. 'In-mixing', although clumsy in sound, suggests the quality of one strand turning in on another strand in a continual internal swirl or dance. The image can be visually expressed in terms of the Chinese Tao-istic relation of yin and yang.

CHAPTER THIRTEEN

Concluding reflections on professional education

It is suggested here that nursing, if it is to be a profession, must be capable of drawing upon its own evidence base derived from its own field of operation in a way that allows independent decision making. Within midwifery practice examples of medical models being dominant over midwifery can be found. However with more practice areas moving to adopt a woman centred approach to maternity care, as contained within the philosophy of Changing Childbirth (Department of Health 1993), more midwives will be developing and utilising a midwifery model.

In Chapter 4 it was argued that professional knowledge is built up over time, as case is compared and contrasted with case within multiple contexts of action. Professional critique comes into being when reflection goes beyond the single instance as the focus in order to understand the single instance in its wider embedding contexts. Only through such a process of contextual analysis can alternative, more far reaching decisions be made. Schematically:


c1 -> s2
c2 -> s2
cn -> s2
are like
Analysis of:
current case therefore use solution 2
wider biographical context of student; try s3
Analysis of wider departmental and institutional ethos, values, management style, structures, mechanisms, procedures, etc try s4
Analysis of local context, purchaser-provider, Trusts, community practice, professional discourses, etc, try s5
Analysis of the wider national context: the economic and political system, the frameworks of laws; therefore try s6

Professional critique applied to the whole

In a similar temporal structure to that noticed in students' learning, the relevance of their experiences, the professional draws upon past cases for what they can say about a current case, in that way the past experience is always relevant not for what it was, but for what it will have become in some future scenario. The past is always available for re-processing and is thus always differently interpreted. It is this that seems to be characteristic of professional decision making in action, and professional processing for future possible action in other circumstances and contexts.

The problem of how to introduce students to necessary knowledge bases is that of the 'frozen taxonomy'. Here knowledge is logically mapped out according to analytic categories rather than process dimensions. The traditional training syllabi is 'accompanied perhaps by some homilies about the aims of the profession':

> *Knowledge of the kind that does not normally get included in syllabi will not be considered, as attention is focused on the listing of topics or specialisms. To questions about the significance of a quality like 'getting on with people', the usual response is to treat it as an unchanging personal attribute or to assume that it will be acquired on-the-job with no need for any special provision. In special circumstances it might be academicised and included as 'interpersonal skills' or 'psychology'. This knowledge is likely to be labelled and packaged according to traditional assumptions about where and how it will be acquired.*
> (Eraut 1985:119)

In referring to 'codified knowledge' and 'experience driven knowledge' Eraut makes both a useful and an ultimately misleading distinction. It is useful because it characterises an essential felt difference between academic knowledge as being codified into 'cold' theories and 'results' or 'finding's that have been 'tested'; and that of experience-driven knowledge as being 'hot' in the sense of being caught in the middle of circumstances where decisions have to be urgently made in order to save lives or to control situations that would otherwise get out of hand. It is misleading because it establishes or at least reinforces the sense of a dichotomy, an 'either-or', and thus of an unclosable, or at least, a problematic gap between theory and practice. In this circumstance, while the map of theoretical knowledge conceived as being distinct from practical knowledge is in most courses richly drawn, the map of practical knowledge is less clearly and richly developed, or in Eraut's terms, inadequately codified (Eraut 1985). Carter (1985) in discussing the kinds of professional knowledge required by engineers, has developed a taxonomy which attempts to address this problem. He distinguishes three broad categories relevant to produce curricular for students:

(i) knowledge (what the student knows);

(ii) skill (what he/she can do);

(iii) personal qualities (what he/she is).

These three broad categories are then elaborated more complexly to:

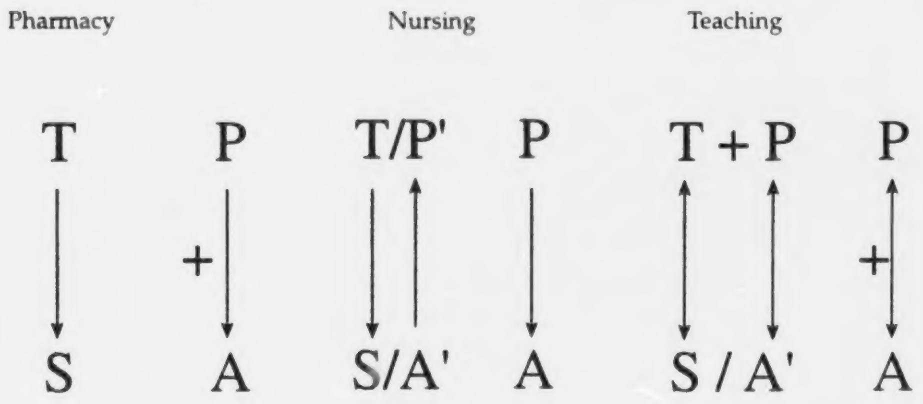
Personal Qualities	Mental Characteristics Openness Agility Imagination Creativity	Attitude and Values Things Self People Groups Ideas	Personality Characteristics Integrity Initiative Industry Emotional resilience	Spiritual Qualities Appreciation Response	Being
Skill	Mental Skills Organisation Analysis Evaluation synthesis	Information Skills Acquisition Recording Remembering Communication	Action Skills Manual Organising Decision making Problem solving	Social Skills Co-operation Leadership Negotiation and persuasion Interviewing	Doing
Knowledge	Factual Knowledge Facts Structures Procedures Concepts Principles		Experiential Knowledge Experience Internalisation Generalisation Abstraction		Knowing
	Cognitive			Affective	

Such a taxonomy does not address the dynamics which are essential if the field of practical knowledge is to encompassed meaningfully.

Thus the knowledge map of a profession is misconceived if it is seen as a 'frozen' taxonomy to be covered as above. It is essential that the 'knowledge map' is conceived dynamically as making sense only through a development of personal experience that is rendered open to public verification and critique. In the process model described above, the knowledge map is derived from the reflection upon the experiences of the learning environment. The learning environment encompasses both clinical and education sites. The challenge is how to manage the process of developing the knowledge map in organisational, curricular terms.

13.4 Organisational models of professional education

The relation between the HE institution and its practice or clinical areas will have implications for the way in which professional education is organised. Barnett, Becher and Cork (1987) construct three models from their analysis of pharmacy, nurse and teacher education:



T=Teacher P=Practitioner S=Student A=Apprentices Dashes (') indicate surrogate role

Models of professional preparation

Although criticisms can be made of the models above, they do provide useful starting points for analysis. First pharmacy:

> *…with its emphasis on hard scientific knowledge and the separateness of the academic and the professional communities, produces a course which is predominantly theoretical. The lecturers acknowledge that their degree courses do not necessarily contribute to the formation of effective practitioners: but nor do they consider that they should. Competence as a practitioner is something which will be acquired in the pre-registration year when the student, having attained a degree, becomes in effect an apprentice whose progress is overseen by a practitioner.*

Referring to the first half of the 1980s, the authors described nursing as follows:

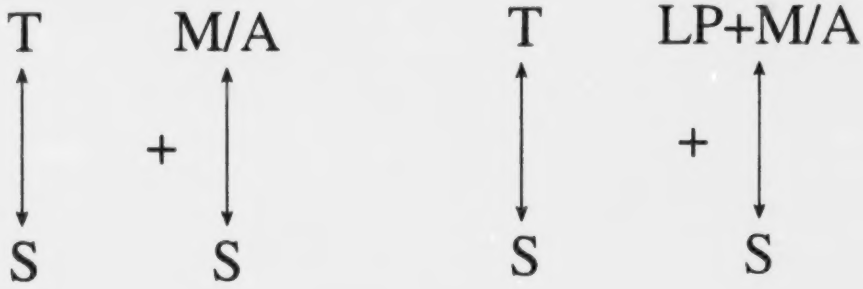
> *Nursing lecturers see it as incumbent on themselves to work alongside their students in the practical as well as the academic setting. In a sense they colonise the territory of the practitioners, not trusting them to take responsibility for the practical training of their students. Academic nurses set out to provide their students with a range of models of clinical practice different from those normally encountered. indeed, they are concerned to the extent to which students might take ward staff as role models, given that "there are few good role models within the nursing profession".*
>
> *All lecturers do some clinical teaching: they work with students on the wards and conduct some ward-based tutorials. In this way, they maintain tight control over both theoretical and practical aspects of the teaching and learning process*

> *throughout the course. Within the clinical situation, they tend to 'hive-off' their students and sequestrate the relevant area of clinical training to themselves. As shown [in the above diagram] the dual teacher/practitioner role adopted by lecturers puts the students in their turn into a dual student/apprentice role.*

The authors considered that the demands on degree students at the time to gain approximately 3000 hours of practical experience led to a heavily over-taught course that in turn gave limited opportunity for them to reflect critically.

The contemporary relationship has changed as a greater separation between HE staff and clinical staff has taken place and a greater consciousness of a professional perspective has emerged. Where teaching as the third comparison group in the Barnett et al (1987) study has increasingly moved into schools and away from HE as the prime locus of 'training', nursing and midwifery have a) moved the locus into HE and b) redefined the relationship of higher education and clinical roles in the educational process. Two broad models appear to be emerging:

MODEL A MODEL B



A=Assessor T=Teacher S=Student M=Mentor LP=Lecturer Practitioner

In these models the apprenticeship role has been supplanted by the student role and the practitioner role transformed to that of mentor, assessor and lecturer practitioner. These are significant developments both for the student and the practitioner. The practitioner does not have an apprentice but acts as a mentor to a student (with the role including questioning, researching and formulating plans for care) or an assessor of student practice. The student is potentially a change agent, something that both HE and clinical staff recognise. The mentor, assessor and in particular the lecturer practitioner are educators, ideally engaged in making manifest their own reflective practice in a dialogic relationship with the student (see ACE Final Report, Bedford et al 1993). Recalling the model of case generalisation and decision making outlined in section 13.2 and earlier in this section, the implication for professional education is that the student must be engaged in the processes of knowledge creation itself. The emergent models of the relation between HE and the practice areas would then need to be interpreted in light of this. The roles of the mentor and the assessor in model A are critical and if the mentor or assessor are insufficiently prepared for their new roles then model A is likely to fail. Model B is buttressed by the role of the lecturer practitioner.

13.5 The discourses of reflection

As Chapter 7 discussed, it is not uncommon to hear accounts of placement experiences that reveal the difficulties of gaining experiences in the 'student role'. It will, at this point, be useful to review further some aspects of the role:

> *The other day a doctor was doing something, I think it was a drain to do with emphysema or something, empyaema, and he said, "Oh do you want to come and watch?" and I said, "I can't, there's not enough staff on the ward and so I could go and they wouldn't let me go anyway, even though they should do really but they couldn't so I couldn't go and see that. But I have been on my surgical allocations, I managed to go for them.*

A key function of practical experience is to familiarise the student with a sufficient range of experience to begin the process of reflection on practice. This process requires at its minimum at least the ability to be able to recall events and to be able to interpret current events in the light of past experiences. This is the beginning of what may be called 'reading the situation'. It is a process which is familiar to most people, and as a process of telling anecdotes forms the basis of everyday conversation. Beyond this is the professional process of case analysis and professional critique described in earlier sections. One lecturer talked of the importance of generating professional critique in terms of its politics, in terms of building up 'networks of influence':

> *I think there is a political dimension. I feel that a nurse that isn't aware of that um and who is not in any way going to work within that to improve the service to the patient is not actually working in a professional manner.*

In her view 'what we're saying is that a professional nurse actually acts as a change agent' in the community and in practice in the service of clients. Students may be aware of such aspirations but also set them within the realistic constraints of their situations:

> Researcher: *Mmm, because there is that, I mean you've got that aspiration, that high professional aspiration for nursing, you know, at least it is being pursued more significantly perhaps through the degree courses, the degree nurse. Yet at the same time the reality is more pressure, more pressure, more pressure.*
>
> Student 1: *I think we've got a lot of high ideals and I think it's good to have those ideals, and the course has taught us what good professional care would be. But then, and like a lot of it on our course is about communication and listening to patients and this sort of thing. But in reality you just can not sit down…*
>
> Student 3: *…when you're given 12 patients…*
>
> Student 1: *You'd love to but you can't and I think in some ways that makes it even more frustrating because you know that it would be good professional care to do this and you know it would help them, psychological support and you know how beneficial it is, and you're read all the research to know how good this is, but then you've got to take someone to theatre and someone's just come back from theatre and you've got to do those sorts of things, and someone needs a bedpan and so it goes on and I think it's awful…*

Student 3: *I think as a degree nurse perhaps you see it more and that makes it more stressful because you know you can't do it.*

Student 1: *And you don't like to accept it either, well I don't.*

Researcher: *But you still say it's good to have those aspirations?*

Student 1: *Yeah I think so, otherwise you'll be stuck in a rut and it will get worse, and you won't have a voice to complain because you won't know what you've got to complain about. I think. I think it's good to be educated and to realise there's problems and you've got to try and sort them out somehow.*

Researcher: *Do you think that when you're saying it's good to be educated and have those aspirations, do you think you'll be more active in speaking out for…politically active with a small p, you know, more confident doing that?*

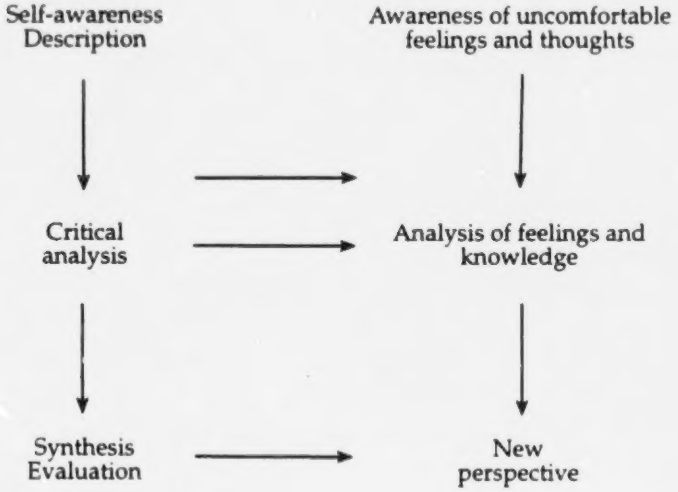
Student 4: *I think so yeah.*

Student 3: *I don't think when you're a staff nurse you're gonna sit back, you're gonna voice your opinion whether you can change it or not.*

Student 1: *Our course has also encouraged us to think about being the voice of the(?) and all that…*

Student 4: *…and to criticise things.*

Change is not a simple matter. These students are aware of the pressures, the constraints and the potentials. These pressures can trigger a train of reflection which is essential to the model of the reflective practitioner which is commonly espoused by courses of professional education. Atkins and Murphy (1993) in a brief review of the literature, conclude that there have been 'relatively few research studies focusing on reflection'; and indeed, there is a lack of agreed definitions which makes comparison between studies difficult. From their review they propose a model which begins in the awareness of uncomfortable feelings and thoughts, leads to a critical analysis of feelings and knowledge, which results eventually in a new perspective on the situation. The full model is shown as follows:

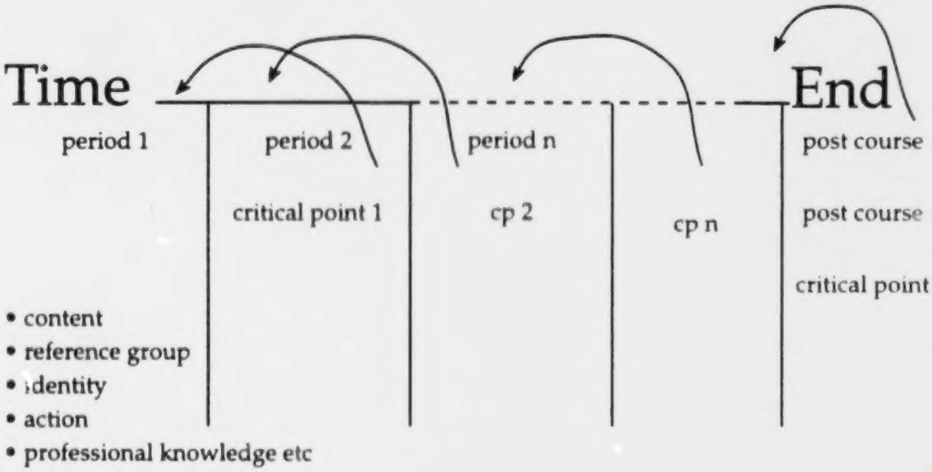

Self-awareness
Description
Awareness of uncomfortable feelings and thoughts
Critical analysis
Analysis of feelings and knowledge
Synthesis
Evaluation
New perspective

Briefly stated, the model requires that the feelings of discomfort are described in order to promote, in the first instance, higher levels of self-awareness. Once a good description has been made then there is a process of critical analysis of feelings in relation to knowledge. Finally, an evaluation is made of the situation which gave rise to the feelings of discomfort which may then result in a new perspective on the situation. The model is helpful but still not clear in what actually happens in the process of reflection and how each stage leads to the next.

The processes of professional critique and action need further elaboration. It may be true that a trigger to reflection is a feeling of discomfort about a situation. However, everyday professional decision making always requires some level of reflection upon the similarities and dissimilarities of cases. Hence, reflection does not require the special circumstance of troubling thoughts in order to commence. Rather, it may be the process of reflection itself that gives rise to troubled thoughts and feelings.

13.6 Time and critical experiences in the process of learning

For the student, critical experiences cannot be had within the confines of the HE institution alone. Something becomes a critical incident, point in time or experience in the lives of the students in retrospection. At the time such an event occurred it may have made no sense. Only later, after several other kinds of experience does some kind of gestalt or synthesis occur in which the isolated event comes to make sense as a part of the whole. Such critical points may be referred to in terms of particular periods of time. There is the period of time before, during and after the critical point. Such periods of time are subjectively defined and may or may not be the same as timetabled periods such as 'semester 1' or 'year 2'. In this reflection back upon a given period, content in that period may make sense only after, say, experience in the placement area. For example, towards the end of the course there is the feeling that 'it all fits in' as students take on their professional identity and begin to practice with increasing confidence. This can be sketched as:



In one sense the passage of time may be thought of in linear terms. However, events in time get organised in terms of periods. These periods are subjectively constituted, perhaps framed in terms of some significant or critical point (cp). Time then only comes into being as a meaningful unit. Any event that happens has a particular kind of meaning when it is happening, but also carries a kind of anticipation in terms of 'what it will have become' at some future point. There is an assumed point of time when the fragmentary or apparently meaningless incidents and events all come together in an explanatory synthesis. However, how do such moments of synthesis actually take place, or come into being for the student?

The manner in which the critical point (cp) may come about may be a) ad hoc, b) accident, or c) strategically as an essential part of the course structured into its processes. The above model, taken together with the previous discussions on the processes of case generalisation and contextual analysis, while still crude, already points to the important implications that:

- time is periodised (subjectively);
- the periods are separated in terms of critical turning points or transition points (e.g., 'in the first year it made no sense but by the second year it all fitted together');
- the student progressively takes on the role of knowledge creator (that is, synthesiser of prior fragmentary or disconnected aspects of experience) as essential to professional practice.

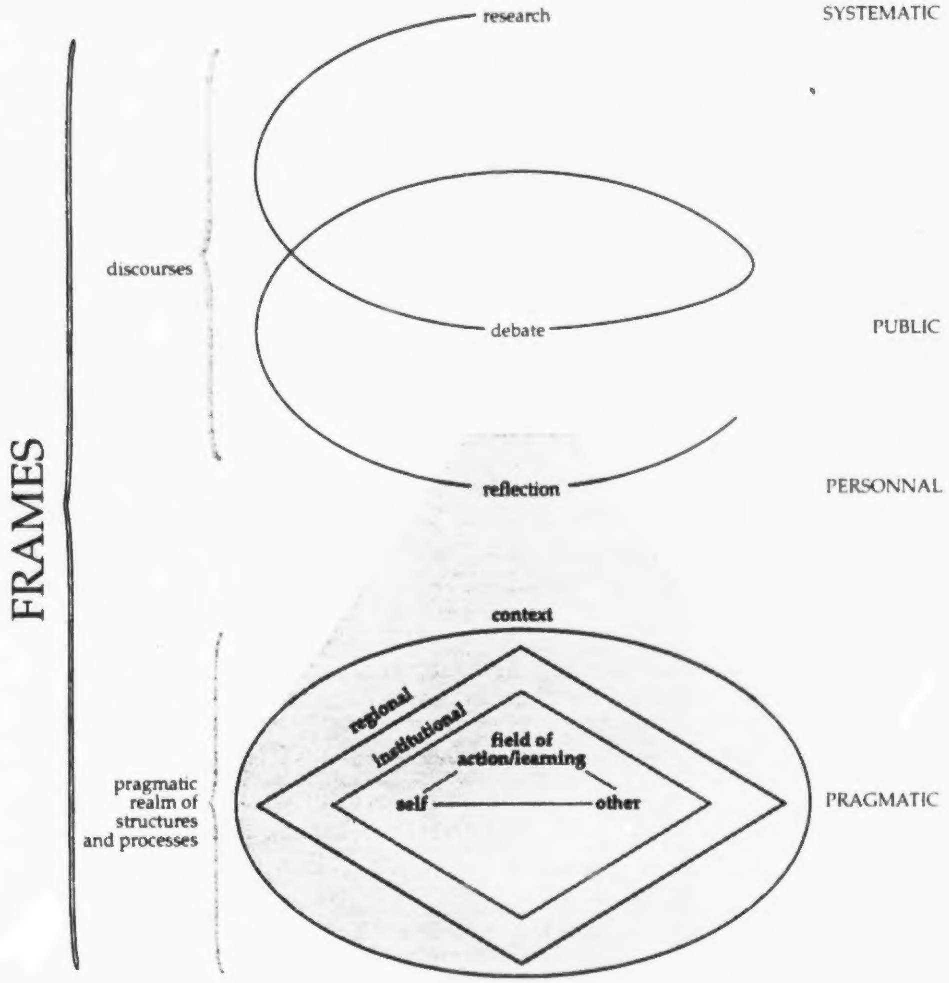
What may be important in this formulation for professional education is not so much whether a course is three years or four years in duration but how the transition points are managed in order to promote meaningful syntheses of experience and how they are strategically employed as integral to the learning process.

13.7 Summary: from a model to principles

Having explored throughout the report various dimensions of a model of professional practice and development that seems implicit in the visions that nursing and midwifery have for themselves, what principles would be appropriate to articulate that model in practice?

The best way of visualising the model that has been developed is in terms of the hypermedia productions that can now be found quite commonly on CD roms and the Internet. Each term of the model should be pictured as like a window to another vista. So pointing to 'contexts' a 'drop down menu' would appear listing all the possible contexts that could be explored. Choosing any one context would then lead to further windows being opened that would provide detailed discussions and descriptions which would then offer the chance to go 'deeper' into detailed analysis through other 'windows'. And so on for each of the key terms of the model. Clearly, no such opportunity can be offered in traditional print forms. Indeed, the description just made of the hyper media presentation could not fully complete the model. In both versions, the model can only be finished through imagination.

The model must be read and interpreted in the context of the whole report and in relation to the experience and imagination of the reader.


research
SYSTEMATIC
discourses
debate
PUBLIC
reflection
PERSONNAL
FRAMES
context
regional
institutional
field of
action/learning
self
other
pragmatic realm of structures and processes
PRAGMATIC

The model divides into two broad 'parts': the discursive level of reflection, debate and research based knowledge production; the objects of the discourse which is the whole context surrounding practical everyday affairs. The model suggests the spiral effect of: a) private reflection upon experience, with its attempts to use past cases for present purposes; b) bringing personal reflections out into the public arena of shared discussion and debate; and c) subjecting these to more rigorous levels of research based activity. These different reflective discourses can be metaphorically imagined as a floodlight falling upon the pragmatic realm of everyday life and all the material structures and processes that sustain it. More specifically, this realm that arises as the object of reflective discourses can be analysed (according to need, insight and imagination) into the key contexts which impact upon the case that has been identified for study. The case itself can be initially described in terms of the 'self' as actor directed towards the 'other' (as client, as family of client, as community of client, as colleague, member of relevant other profession, or as management within a given institution, or as policy maker and so on).

Self and other interact upon a given stage or set of stages with all the attendant props appropriate to a given stage (i.e., stage as scene of action rather than as developmental stage). Self in interaction with other on a given stage defines the twin dimensions of field of action and field of learning. In terms of the delivery of care and reflection upon the delivery of care this is effectively the 'learning environment' as initially described and explored in Chapters 4 to 8. The challenge for educationists (in HE clinical areas) is how to design organisational and management structures, mechanisms, procedures and curricula which reinforce the cultural embedding of reflective discourses within the pragmatic realm of occupational culture and practice. The more that reflective processes are embedded culturally, the more it is a vital, creative, living phenomenon and the less formal 'management' required to make it happen. These create the dispositions at personal, interpersonal and organisational levels that become the frames through which professional activities are accomplished in everyday life.

The underlying principle to be culturally embedded is that of dialogue for mutual education. How this is actually articulated as a recommendation for practice depends upon the specific historical culture, practices and structures of a given institution within its local context. Hence, this report will end in a description and discussion of principles.

CHAPTER FOURTEEN

Criteria for a quality undergraduate degree

Introduction

This chapter recapitulates and integrates the research findings set out fully in the rest of this report and attempts to encapsulate the arguments that have developed from them. It offers (a) *principles* for considering proposed curricula for undergraduate nursing and midwifery education, and (b) an indication of some of the *structures* and *frames* which have been noted in the research as major factors contributing to the development of a curriculum for high quality, client-focused nursing and midwifery practice.

- The principles propose criteria for achieving a quality undergraduate professional degree. They are intended as a basis for discussion about quality and the policy and resource implications of seeking quality.
- The frames indicate institutional climates and individual dispositions which are instrumental in shaping the conditions for educative preparation for professional practice.
- The structures indicate some of the mechanisms and strategies which enable the realisation of curriculum aspirations expressed in principles.

Differences between local contexts mean that there will always be a need for dialogue to establish which particular frames and structures are appropriate for implementing a given principle in a particular institution.

Criteria that tried to specify structures for all contexts would be inappropriate and almost certainly unworkable.

14.1 Structuring educational processes

If a degree is to realise both its professional and educational aspirations its curriculum will need to articulate a set of principles and show what structures are in place to help realise them. These structures will be of three kinds. There will be material structures for enabling institution-wide implementation of the educational process, (e.g. timetables, rooms, clinical placements, information packages). There will be non-material structures for promoting particular processes in specific contexts (eg. 'mechanisms' for dialogue, decision-making, and prioritisation). And there will be 'organic' structures which contribute to the shaping of individual attitudes and institutional dispositions (e.g. flexibility, adaptability, responsiveness to the unexpected, risk-taking). These latter are better conceptualised as 'frames'; that is, spaces for shaping attitudes, understanding, and cultural practices.

Non-material structures and dispositional frames act as forms of 'structuration' (Giddens 1993). Frames 'structure' symbolic environments and orientations and thereby create the conditions for cultural transformation. New theories and practice, new (intermediate) 'traditions', are thus established. Structures and frames together create the conditions for enacting educational processes in clinical and HE contexts. A curriculum shaped by a coherent set of principles, structures and frames will increase students' subjective 'grasp' of nursing or midwifery.

Principle 1. 1
Degree programmes should specify key principles, and identify the structures & frames through which it will realise them

Degree programmes should (a) make explicit the principles which underpin the curriculum, (b) make an honest evaluation of the institutional climates which will frame the curriculum, and (c) identify specific structures through which principles will be realised.

The key structures for enabling this principle are:

- the curriculum itself;
- curriculum task groups whose brief it is to identify problem-solving structures that place vision, theory, and practice into a relationship which can be presented in a curriculum model.

The frame most likely to ensure that these structures are effective in realising the principle is:

- a policy requirement that curriculum principles be made explicit and supported by identified structures.

Undergraduate degrees in nursing and midwifery, in common with other professional degrees, have to prepare students for practice. Other kinds of degree have only to offer students access to a body of knowledge; the application of that knowledge is not a matter of direct concern, neither is the personal competence of the student. The curriculum for a professional degree must be constructed in a way that *ensures* :

- an interaction between professional 'vision', theory and practice;

- critical and constructive reflection on that interaction to ensure discrimination between occupational socialisation and education.

A professional degree must, therefore, *incorporate in the curriculum itself* appropriate structures and frames for supporting the general principles which relate to these requirements:

Principle 1.2
Degree programmes should show how educational processes will be promoted and sustained

Degree programmes should include structures for reviewing the relationship between 'vision' (philosophy and aspiration) and the actual degree. These structures must place educational processes at the centre of the curriculum.

The structures which have promoted this principle include the following:

- teacher/mentor/assessor/student meetings to map problems of fit between theory and practice;
- classroom activities (which may include simulations) in which teachers and students work with examples of apparent mismatch to build a map of the problem-structure;
- classroom activities in which students working in teams are asked to solve particular problems using a previously-designed problem-structure map;
- reflection on practice experience issues (e.g. mapping the problem structure and possible solutions to compromise of students' supernumerary status – see Chapter 7, section 7.6).

The frame that is most influential in making the structures effective is:

- a teaching/learning climate in which problems of mismatch between theory and practice, or aspiration and actuality, are treated as opportunities for educational dialogue rather than proof that one or the other is 'deficient'.

14.2 Avoiding unacceptable compromise

The viability of a proposed degree will depend in large measure upon the extent to which its educational aspirations can be met, taking account of local clinical and economic contexts. Every nursing and midwifery degree is different from every other because each programme is the outcome of an attempt to work out a broadly agreed national nursing/midwifery vision within unique clinical and higher education contexts. Individual courses have to make sense in terms of both a conceptual and an operational *ideal;* they also have to work in *actual* local circumstances. They must, therefore, bring

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together educational imagination and operational pragmatism in ways that avoid *unacceptable* compromise of educational principles.

Principle 2.1
Degree programmes should establish criteria of unacceptable compromise

A degree programme for professional practice must incorporate structures for deciding what constitutes an unacceptable compromise of its educational agenda. It must show that there are effective means for guarding against unacceptable compromise in educational quality.

The structures employed for this purpose include the following:

- resource allocation and personnel management committees which include among the membership those with senior educational management responsibility for 'delivering' education quality levels;
- publicly available minutes of resourcing committees;
- processes for monitoring the deliberations of resource management teams;
- processes for making representation to resource managers when, following evaluation of a given element of resource policy, a democratic decision is taken deeming the outcome of that policy to require unacceptable compromise of educational principles;
- procedures for the representation of teachers and students on any committee concerned with such monitoring;
- procedures for regular communication between local stakeholders in nursing and midwifery education, for the purpose of monitoring standards of clinical placements and supervision.

The frames which enables this principle to be realised are:

- a commitment to quality through democratic processes of consultation;
- a commitment to accountability for standards of education as complementary to accountability for standards of practice and the 'delivery' of quality care.

Where principles are adopted without adequate resources, they tend to remain at the level of *'mere'* rhetoric, or high-sounding words that do not result in action. Where 'guaranteed' resources are withdrawn for operational reasons, expectations are dashed. Education cannot produce students committed to a visionary concept of care in circumstances where there are inadequate resources to establish an infrastructure for transforming attitudes and enacting the vision in practice. What it will produce instead is disappointment and cynicism. In preparing a professional degree, course planners must take particular account of the need to support high professional aspirations with resources and structures that enable their realisation.

Principle 2.2
Degree programmes should have credibility assurance procedures

A degree programme must have procedures for (a) gathering intelligence about resourcing, (b) identifying – with budget-holders and managers – where professional and educational principles may be threatened , and (c) negotiating resource levels that maintain the credibility of the degree in terms of those principles.

The structures and frames for implementing this principle are:

- as for principle 2.1.

Any professional degree must respond to two apparently contradictory demands. It must be realistic in terms of national political, social, and economic agendas and in terms of given local institutional contexts. On the other hand, it must be able to withstand pressures to unacceptably compromise its 'vision'. Dissonance between the two is common, particularly during periods of transition that accompany mergers and amalgamations. Degree programmes must, therefore, incorporate ways of monitoring and affecting the fit between them. This will require dialogue between programme providers and managers to ensure organisational sensitivity to internal and external constraints. One intention of the dialogue will be to produce strategies and action plans for addressing the threat of potential compromise.

Principle 2.3
Degree programmes should specify structures for dialogue to ensure a fit between 'vision' and realisation

A degree programme must incorporate dialogue structures to facilitate monitoring of the relationship between curriculum aspirations and what actually happens on the course. These structures must (a) be capable of identifying and responding to proposed changes in institutional and operational contexts, where these are likely to make it more difficult to realise the 'vision', and (b) involve 'grass-roots' teachers, clinicians, other relevant professional representatives, and senior management.

Structures and frames:

- as for principle 2.1.

14.3 Planning for coherence

Coherence is about 'connections', 'relations between parts' and 'understanding'. A coherent knowledge context provides the condition for the creation of new knowledge and understanding in relation to an ever-widening range of cases. It is achieved when ideas are successfully brought together, when people and agencies are in purposeful communication, and diverse experiences are co-ordinated through discussion. Undergraduates' and graduates' comments suggest that the least stressful degrees are those which have the greatest element of coherence, and report greatest dissatisfaction with those courses which they perceive as lacking coherence and thereby preparing them less well for the learning situations they encounter. Students feel pressure when faced with having to create coherence for themselves from a large variety of different and apparently unconnected theories and a wide range of contexts. They express confusion where theory is fragmented into disciplines, and complain about the lack of any prior synthesis between different parts of the course. Students perceive their task as made more difficult by interaction with lecturers and clinicians who do not appear to have a common view about learning priorities.

Ironically, by pre-structuring to ensure an element of coherence, a course team can facilitate students' own development as theory-builders. The successful degree appears to be one for which the curriculum has been structured, at the planning stage, to enable (a) exploration of experience in relation to a range of relevant bodies of knowledge (b) evaluation of the contribution of different bodies of knowledge to nursing or midwifery, and (c) the building of theories of nursing or midwifery.

Principle 3.1
Degree programmes should specify mechanisms for developing coherence across 'discipline' boundaries

A degree programme must be structured, through the curriculum itself, to enable and sustain critical reflection over a wide range of fields of knowledge and action. The curriculum must embed processes which facilitate the mapping and exploration of experience in relation to those bodies of knowledge, and encourage critical reflection on both experience and knowledge.

This principle has been realised through the following structures:

- portfolios of evidence from practice which are used as the focus for theory-building in the classroom;
- assignments which require the presentation and analysis of detailed evidence (from portfolios) from a range of experiences of practice;
- assignments set jointly by teachers from two or more contributory disciplines, requiring the exploration of data from more than one perspective;

- team planning, and where possible team teaching, by members of staff from different contributory disciplines and/or professions;
- cycles of reflection and action which enable (a) critique of particular practices and specific parts of theory in relation to at least one other element of practice/theory, (b) evaluation of action that follows from this critique, and (c) further critical reflection on emergent theories of practice, with a view to identifying generic principles.

Among the frames which contribute to the construction of coherence through these structures, are:

- a disposition to treat theories as provisional until tested in practice;
- a readiness to treat practice as founded on provisional theories which should be regularly examined in the light of developing experience of practice and general theory;
- a readiness to explore action in terms of contributory disciplines.

None of the factors mentioned above as a cause of incoherence is peculiar to degrees in nursing and midwifery. Students on many other undergraduate programmes could report similar problems. It is, in fact, a deliberate part of higher education policy in many institutions to expose students to different points of view and expect them to evaluate these for themselves. And although no university department is happy about the under-resourcing which often lies behind inadequate inter-site transport and poor communication, many of them suffer its consequences. The difference is that in the case of the professional degree, lack of coherence *directly* affects teaching and learning and may as a consequence affect professional practice. In addition, there are financial and organisational constraints on undergraduates following a practical professional degree which are considerably higher than those for students on other degrees. Because they spend large amounts of time travelling between sites, making arrangements for liaison with teachers, mentors, and assessors, and coping with the organisational consequences of breakdowns in communication between groups and institutions, while at the same time doing paid agency work to supplement their grant, nursing and midwifery students have reduced time for reflection.

A course which offers neither an integrated professional perspective nor a set of strategies for constructive critical appraisal as a way of building coherence will leave students with piecemeal knowledge and hinder their theory-building.

To ensure an undergraduate experience which not only provides students with a high quality educational experience but also successfully prepares them for high quality practice, a degree programme must be organised to facilitate *coherence*. Nursing and midwifery theory must hang together sufficiently to be of use in practice. Limited and increasingly expensive human and clinical resources must be organised to maximise clinical learning opportunities. Communication between teachers, and practitioners must be co-ordinated to enable students to devote their attention to *doing* and *reflecting* during clinical placement. In light of evidence that key members of a teaching team (eg, clinical practitioners and staff located in contributory departments) are often less able to attend curriculum planning events, structures for coherence should offer a forum to *all* interested parties.

Principle 3.2
Degree programmes should show evidence of inter-professional and inter-disciplinary planning

Degree programmes must provide evidence that staff preparation and curriculum planning have involved lecturers and clinical practitioners from each of the complementary professions and contributory disciplines in the shared preparation of programmes that are coherent with respect to the professional aspirations identified in relevant parts of the UKCC professional register.

Structures which enable this principle include:

- inter-disciplinary and inter-professional planning teams;
- provision of designated time for curriculum planning by cross-boundary groups;
- provision of one afternoon's non-timetabled time for all members of faculties involved in the teaching of undergraduate programmes in nursing/midwifery to meet together for planning (usually as part of the one teaching-commitment- free day a week created by a whole institution timetabling policy).

Frames for achieving this principle:

- as for principle 3.1, but see also Chapter 4. Section 4.6.

14.4 Creating coherence through the exploration of discourses

Although an increase in coherence can be achieved through careful planning to pre-structure key elements of theory, allocate clinical space and time, and establish appropriate communication channels, there is evidence that there are often insufficient resources of personnel and time to permit as much care at the planning stage as most planners would desire. Curriculum planning is often done in a hurry by small delegated groups, some of whom have little previous experience. The consequence is that from the outset, coherence is only partially achieved. Further coherence has to be constructed retrospectively in a piecemeal way in the process of course delivery. This process of retrospective coherence construction, unless deliberately included as a curriculum activity and supported through the allocation of time for curriculum revision, is stressful for both teachers and students.

From an educational perspective, the fact that coherence is something which has to be continually recreated (for whatever reason), provides an interesting challenge. What is required are structures for problem-solving to allow lack of coherence to be addressed regularly throughout the life of a course. A degree programme should, therefore, incorporate effective structures for revision that include *educational* discussion between students, teachers, and mentors.

Principle 4.1
Degree programmes should specify structures for dialogue to explore areas of apparent incoherence and disagreement

Degree programmes should recognise that prior planning alone is unlikely to achieve the desired level of coherence, necessary for a professional degree, and should (a) incorporate structures for identifying and exploring the educational discourses in areas of incoherence, (b) make provision for students and mentors (together and separately) to participate in this exploration as part of the curriculum.

This principle has been realised through the following structures:

- evaluation teams that include all those involved in teaching, mentoring, and assessing students (including students themselves);
- auditing procedures that enable the co-ordination of learning opportunities across a wide range of practical situations and clinical placements;
- frequent context- and person- sensitive 'audit' during teaching staff visits to clinical areas (as part of the nursing and midwifery lecturers' 0.2 WTE commitment to practice)[1];
- review groups that include student participants.

And is facilitated where dispositions are shaped by frames such as the following:

- an orientation to discuss incoherence as a basis for the development of theoretical understanding;
- a perception of the discussion of difference as a way to enable transition from simple to complex understanding of experience;
- a teaching/learning climate which permits lecturing and clinical staff to draw on each others' strengths;
- a readiness to acknowledge that 'not knowing everything' is a natural educational state.

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[1] ENB, 1993:2.14 in ENB, 1993-1995). This has been realised at some, but not all, institutions (see sections 5.2 in Chapter 5, 6.2 in Chapter 6 and 7.7.2 in Chapter 7). The final point in section 7.8 of Chapter 7 provides further elaboration of this structure.

Structures for the exploration of apparent incoherence should themselves be kept under constant review. One danger in attempting to ensure coherence is that it might lead to an expectation that there is somewhere a singular, univocal theory. Trying to achieve coherence by means of a 'singular' theory of nursing or midwifery would be as inappropriate as setting out to achieve coherence in practice by imposing a single set of procedures on all clinical practice. Coherence is not achieved by silencing alternative 'voices'. Instead, it is accomplished through dialogue which (a) acknowledges that different voices exist, (b) seeks to identify common ground, and (c) explores differences in a principled manner. Where coherence of this kind is established, students who are already pressured by shortage of time and heavy workloads, are relieved of the additional pressure of trying to create a single, authorised story in the privacy of their own heads.

Principle 4.2
Degree programmes should specify dialogue structures for the exploration of theory and practice discourses.

Degree programmes should include structures to enable the in-course creation of a coherent nursing/midwifery theory through identification, exploration, and evaluation of (a) differences between theoretical discourses, (b) differences between practical discourses, and (c) differences between the discourses of theory and practice.

This principle has been realised through the following structures:

- a timetable that allows sufficient time for regular reflection through discussion of differences in perception, practice, belief, and value;
- teaching and learning programmes that focus on the exploration of discourse differences without attempting to reduce them to a single view;
- teaching materials chosen deliberately to identify a range of views;
- assessment of clinical practice that addresses differences in practitioners' perceptions of competence, as a means of exploring beliefs, values, and discourses;
- consultation processes that enable discussion about action to change practice where contradictory views cannot be accommodated through dialogue.

And is facilitated where dispositions are shaped by frames such as the following:

- a readiness among teachers, students and practitioners to engage rigorously in interrogating theories and practice to identify the values embedded in them;

- a climate that encourages the discussion of apparent oppositions between theory/practice discourses, as an educational act which will lead to transformation in perceptions of both;
- an orientation to critique, through reflective practice, rather than criticism;
- a willingness to seek collaboration to change the context of practice where it becomes apparent that this affects practice in ways that are inconsistent with the *range* of values and beliefs that emerge through discussion as acceptable.

14.5 Quality, range and relevance of learning experience

In a professional degree the *quality, range,* and *relevance* of learning experience matters considerably. If a student's clinical experience is poor with respect to these, learning will be adversely affected. In organising access to clinical environments, course providers must try to ensure that the experience is relevant to students' current studies and interests. At the same time they must, as far as possible, see that the total placement package equips students with a repertoire of different types of contextualised clinical experience. On the other hand, if a student's classroom experience fails to provide them with a wide range of relevant theory, or offers insufficient opportunity for evaluating theory and practice through a reflexive examination of each in relation to the other, learning will again fail to meet expectations. Courses must enable students to have access to relevant knowledge as it becomes necessary, while ensuring that theory is not made trivial through fragmentation.

These difficult balances are most satisfactorily achieved where learning opportunities and interactions are monitored and developed as an integral part of a continuous mutual education process.

Principle 5.1
Degree programmes should specify mechanisms for the ontinuous audit of the quality, range, and relevance of learning experiences

A degree programme for professional practice must incorporate at the centre of the curriculum (a) structures for continuous audit, through dialogue, of the quality, range, and relevance of clinical and classroom experience, (b) structures for quality development through informal in-service education[2]*, and (c) structures for mapping the problems of quality maintenance.*

Judgements about relevance are often best made by students themselves. It is the student who is in a position to identify the aspect of theory they require to solve a particular problem. The curriculum must ensure quality and range, but should encourage students to take responsibility for accessing particular elements of relevant theory as and when these are required by the task to be undertaken. Tasks may be focused through assignment specifications or clinical placement assessment schedules, but the student will retain responsibility for deciding what elements of theory and practice to refer to in tackling the task. If these are to have an educative function, however, curriculum teams must have a detailed knowledge of the opportunities and limitations of clinical learning environments, so that they are in a position to judge relevance and help students find their own relevance.

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[2] The term 'in-service education' is used to describe the process of continuous interaction between educators and practitioners which leads to personal and professional development. It is not intended, as is often the case, to refer specifically to packages purchased by providers to meet a particular need they have for up-dating, etc.

Structures and frames:

- The principle is supported by structures set out Chapter 7 summary points c and d in Section 7.8, and Chapter 8.

Principle 5.2
Degree programmes hould identify strategies for supporting students in deciding what constitutes relevance

A degree programme for students who, on qualification will be required to access and use knowledge on a regular basis in their daily practice, must encourage excellence in information-seeking and handling by (a) handing the responsibility to student for seeking further information/evidence from theory/practice as it is required, (b) properly resourcing information and data organising systems, and (c) enabling access to those systems.

Among the structures which contribute to the realisation of this principle are:

- electronic computer networks for student access to catalogues of book titles, journal articles, and research publications;
- student access directly to articles through the Internet;
- library resourcing which recognises (a) the non-standard hours and (b) the non-standard term times which nursing and midwifery students are obliged to work;
- library resourcing which recognises the multi-site nature of learning for professional practice;
- student representation on library/computing resource committees.

Frames which orientate students towards achieving the principle are:

- a climate which encourages student independence in seeking relevant research/information at the point of need;

- an organisational climate which, by precluding the necessity for creating *basic* coherence, increases the time available for accessing information which will enable deeper exploration of key issues.

14.6 Foregrounding educational dialogue in the organisation

The aspirations of nursing and midwifery educators are high. Their curriculum documents show that they are trying to 'deliver' the ambitious curriculum implied in government and professional policy documents about nursing and midwifery in the twenty-first century, while in many cases also introducing innovations of their own. They are attempting to prepare professionals who are competent, knowledgeable, ethical, reflective, and highly committed.

The educational skills which make 'delivery' of this curriculum possible, namely evidence and information gathering, reflection and critical analysis, decision-making and judgement, have to be developed in the context of practice and patient care, for which a range of competencies is also required. The degree must, therefore, attend to the agendas of both education and practice, agendas which do not always fully coincide.

The challenge does not stop here, either. A professional degree not only has to take into account the different demands of educational and clinical agendas, but also the agendas of those whose interest is management, research, or employment in the market, or whose perspective is from within a discipline (and hence a department) other than nursing or midwifery. Each of these interest groups is affected by material and dispositional frames which others need to be aware of if they are to co-operate.

As individuals, as well as role-holders, people need to know where their concerns parallel those of other groups and where there are points of significant difference. They need to be in a position to establish mutually agreed priorities, to ensure complementarity of effort and avoid the stressful alternatives of pulling in different directions or duplicating work.

The professional degree must incorporate structures to maintain communication between the various parties involved in making the curriculum happen. Through these structures it must attempt to bring the owners of the different 'voices' into dialogue so that they can identify points of intellectual and dispositional difference between them, and begin to explore the theoretical and practical implications of these.

Principle 6.1
Degree programmes should demonstrate that they have structures for establishing and maintaining dialogue

Degree programmes must be supported by structures for maintaining dialogue between different interest groups. One of the key functions of these structures will be to bring together those with professional, academic, clinical, management or research concerns and offer them a forum for better understanding of each others' needs and aspirations.

Structures for dialogue which have been observed in use include:

- cross-interest task groups;
- inter-group seminars;
- joint curriculum planning meetings;
- thematically-focused groups;
- collaborative setting of assessment tasks;
- evaluation meetings at which a wide range of interests is represented.

The key frame which contributes to the implementation of this principle, is:

- willingness to treat dialogue as an opportunity to discuss educational agendas with others whose interest is primarily of a different sort, with a view to greater understanding on both sides.

The setting up of task groups, seminars, planning meetings, and the like is not of itself sufficient to ensure dialogue, however. Some meetings become the arena for representatives from different academic and professional disciplines to defend territorial boundaries, others become occasions for haggling over the same limited set of resources, and some reduce 'consultation' to a process of information transmission. What occurs then is a series of monologues rather than an educational dialogue.

Educational dialogue requires openness, characterised by a willingness to express and critically examine together all points of view. Being predicated on the assumption that mutual understanding is most likely to be achieved where participants have equal rights, it requires the suspension of hierarchy. It is not simply a 'talking shop', however, because its main purpose is to improve understanding and establish common cause in preparation for agreed action. Its structures are largely dispositional frames; these, however, are encouraged through procedures and may result in an action outcome.

Principle 6.2
Degree programmes should identify the educational groundrules which are to guide dialogue

Degree programmes must be supported by structures for dialogue which employ educational/democratic procedures and institutionalise groundrules for the joint exploration of areas of difference.

Structures which have helped to make dialogue educational include the following:

- procedures for securing an *agreed* agenda;
- procedures for securing a set of mutually agreed groundrules;
- procedures for securing agreement on the time allocated for discussion on any particular issue;
- procedures for recording points of difference as well as agreement;
- procedures for securing an agenda for action;
- flattened hierarchies

Frames include:

- a disposition to prioritise educational issues above procedural ones;
- a commitment to democratic principles;
- a commitment to reducing hierarchy.

14.7 Supporting the process of critical reflection

According to the DoH, the education of nurses and midwives should provide *'a comprehensive knowledge base on which (clinical) practices, and indeed the whole range of health care responsibilities are founded'.* (DoH 1989b p15). The way to do this, they suggest, is by fostering students' *'awareness of and ability to use research findings'* (DoH 1989b p15) and by helping them develop *'the analytical skills to ask the right questions, to know where to seek answers to them, and to reach informed decisions on the basis of the fullest knowledge available'* (DoH 1989b p24). The ENB similarly exhort the design of curricula which are, *'student centred - recognising the individuality of students and harnessing the wealth of experience they bring to the learning situation (...)'* (ENB 1994 p 2.13 in ENB 1993-1995).

The development of judgement as a key outcome of professional education is increasingly being recognised, 'New opportunities and changing attitudes will pose new ethical challenges for society. (...) Deciding what is right will not get easier, and health professionals will often be at the cutting edge of these debates (...)' (Nursing Strategy Workshop 'Health and Social Care 2010 - Shaping the Future ' 1994 p 3). In 1992, advanced judgement was clearly equated with degree level work when it was stated that *'At diploma level, students (.....) have some basis for informed comment and a level of analytical thinking enabling them to progress into a third year of a degree course'* (ENB 1992: Para. 2.2. Our emphasis)

In short, a major part of the focus of nursing and midwifery education is to be on reflective practice founded in the applied intellectual skills of information synthesis, analysis, critical appraisal, and judgement. These are the key professional processes on which *'the whole range of health care responsibilities are founded'* and are thus, by implication, the 'essential' processes to be learned during the degree.

By the time a student is ready for registration they have to be able to analyse clinical experience in particular contexts, and understand specific academic theories. But it is also expected by registration they will be able to 'apply' an integrated professional body of knowledge across contexts taking account of both local and global values. This is indeed a challenging activity in current contexts of practice. Graduands require systematic help in preparing for what is a complex and sophisticated process, and therefore shared reflection must be a central part of their preparation. This process needs support once the graduate is in their initial preceptorship period (UKCC 1995) if they are to build on their initial internalisation of it during their undergraduate studies, and be in a position to continue it as a major element of their career-long learning.

Because nursing and midwifery are activities which occur in a range of highly specific contexts but involve the use of theories which are applicable across contexts, students must learn to reflect in ways that promote their understanding of the local in relation to the global (and vice versa). This learning cannot be left to chance or to the student's personal development; undergraduate programmes must institutionalise reflective practice by structuring opportunities for shared critical analysis and by offering guidance on how to do it effectively.

Principle 7.1
Degree progammes should specify structures to ensure the provision of time for shared reflection & critical analysis

Degree programmes must enable quality reflective practice by ensuring the provision of time for shared reflection and critical analysis and for the development of explicit strategies for achieving them, with a view to enabling reflection on practice as a career-long learning process.

Among the structures which have been employed to support reflective practice are:

- regular opportunities for students to generate explanations and devise action plans from the data of everyday clinical practice;

- guided exploration of wider professional issues in relation to students' own repertoires of situated cases;
- periodic public evaluations of action in the light of the explanations and categories developed in practice;
- regular student involvement in corporate activities which require explaining, planning, problem-solving, or evaluating;
- the integration of 'theory' through curriculum planning;
- the provision of integrated theory through teaching structures and learning materials;
- the assessment of practice through dialogue about portfolios of evidence;
- programmes to develop the skills of evidence collection, synthesis, and critical analysis per se.

The key facilitating frame is:

- an understanding of reflection as a rigorous activity requiring evidence collection, analysis, synthesis, and critical evaluation.

The educational ideal of reflective practice involves the assessment of options and the making of choices. It requires the systematic development of judgement. As aspiring professionals, students are expected to develop competence in making 'difficult' choices after reflection, but they have relatively little experience of the situations where difficult choices are involved. On a day-to-day basis, the practice of nursing and midwifery requires only the occasional application of this detailed approach. And where such circumstances do arise, a student is often obliged to step back into a dependent 'student' role in the interests of safety. As a consequence, students may experience the degree as 'unrealistic', and feel a certain amount of role strain as they struggle with the dilemma of being student as learner and student as novice practitioner.

Graduates identify lack of preparedness for independent decision-making as one of the problems they face on entering practice. Some practitioners expect newly qualified graduates to be able to make complex decisions in highly specialised. Many graduates feel threatened by these expectations. It is not only that they have had insufficient specialist knowledge, or that they have had little opportunity to practice the very necessary skills in 'difficult' situations, but also that they have not yet gained confidence that they *can* do it.

A curriculum for practice in which judgement and evaluation are elements of the job must avoid adopting 'crude measures' of practice, and must emphasise the complexity of decision-making about clinical, interpersonal, and resource issues in context.

> ***Principle 7.2***
> ***Degree programmes should show how they will provide opportunities for students to engage in consequential judgement /decision-making***
>
> *Degree programmes must enable students to systematically explore choices and make judgements of consequence in both clinical and educational settings. They must, by implication, avoid 'crude measures' and advance the development of judgement based on sound evidence.*

Among the structures in use which support the development of judgement are:

- participation in democratic decision-making in HE based learning (eg. with respect to the order in which curriculum themes are taken; with respect to the day-to-day life of the classroom);
- membership of task groups preparing seminar presentations;
- involvement in joint coursework assignments arising out of practice;
- membership of course committees;
- participation in clinical team decision-making;
- tasks/assignments which foreground reflection which moves rigorously from evidence collection, through analysis and decision-making, to an action outcome;
- a curriculum climate which values research processes.

Facilitating frames include:

- a curriculum climate which values research processes;
- a willingness to provide HE based opportunities for consequential decision-making;
- a recognition of the value of HE learning environments as a relatively 'safe' context for developing skilled judgement .

14.8 Support for teaching staff

Teaching and clinical staff are subject to many of the same pressures as students. They, too, often experience the degree as disjointed and find problems with communication between the various groups with which they have to deal. But the problems are exacerbated for many of them because of the pace and multi-facetedness of change. They are rapidly having to adapt to changing patterns of healthcare and to accept values (eg. marketisation, prioritisation of treatment, and a purchaser-driven education agenda) which they have previously thought alien. And they are having to negotiate with a destabilised and in some cases demoralised occupational group of higher education staff. A degree programme which has structures for coherence and dialogue will not only alleviate some of the practical problems they face, but may also encourage a change in the 'institutional' disposition which is likely to further reduce anxiety.

Structures for educational dialogue will ensure teaching staff meet regularly with managers, purchasers, policy-makers, and clinical staff whose values they can explore in the discourses of the market, competence, professionalism, care, resource management, etc. through which negotiation will be conducted.

Principle 8.1
Degree programmes should indicate where students will have the opportunity to explore the values of others (or the Other')

Degree programmes should incorporate structures which ensure regular meetings between HE stakeholders, clinical stakeholders, and user groups, for the primary (but not necessarily exclusive) purpose of familiarisation with and exploration of each other's discourses.

Structures which have been used to realise this principle, include:

- meetings with invited members of fund-holding bodies, ethics committees, and management teams;
- study sessions for exploring discourses about gender, ethnicity and equality in public texts concerned with the health service, education, and care (eg. newspaper articles; public information leaflets; government working papers);
- discussion of values with assessors during assessment events;
- public debate about controversial perspectives through an invited speaker programme.

The main facilitating frame is:

- genuine curiosity about the perceptions of others.

The morale of staff in departments which have undergone a series of 'rationalisations' through merger is often low. Many university teachers have not yet developed a clear and stable view of their role, while those who have may find it difficult to meet all role demands. Because both teachers and students often have expectations of a high level of teaching contact time from earlier practice, and because of the culture of dependence that this engendered, some staff have found it hard to balance the demand for teaching and research. This leads to guilt about what they perceive as falling standards in teaching, and anxiety about the loss of status which comes from not being engaged in research, particularly funded research.

If a department is to offer high quality teaching and first-rate research it must build a culture which strives for excellence in both. It will not achieve this by exhortation, however, but must instead provide appropriate structures to activate the change. At the very least, it should provide structures which enable staff to look at teaching and research in other institutions, at best it should incorporate into its planning and development, activities which frame a critical appraisal of accepted views and values and foster research-based teaching and research which explores new possibilities. Nursing and midwifery research has often had a clinical focus but there is no reason why nursing and midwifery *education* research should not also be about the ideologies and theories which constitute the professional 'vision' itself. There is no good reason why those values, beliefs, and concepts should be exempt from interrogation, and indeed the questioning of them can be of considerable educational value in helping to make critical appraisal an acceptable part of the culture.

Principle 8.2
Degree programmes should identify structures for developing and maintaining a research -based approach to teaching

Teachers of degree programmes should be supported by structures to facilitate and reward research-based teaching and research initiatives, thereby creating a research culture.

Structures that have been used to help promote a research culture have included:

- small internal budgets to fund 'starter' research;
- collaborative bidding (with colleagues in departments with established track records) for funded research;
- collaborative research with researchers in departments of education;
- research in collaboration with clinical and mentoring staff;
- provision of study leave;
- allocation of time for study in the weekly programme (provided even for those on non-HEFCE contracts);
- assignments that require the comparison and evaluation of papers from different professional standpoints;
- visits to other institutions to see different approaches in operation;

- experiments in collaborative teaching with practitioners.

The key frames are:

- commitment to the development of nursing and midwifery theory through research;
- interest in sharing ideas, through publication, with different but complementary interests.

14.9 Liaison with clinical staff

As suggested earlier, the quality of learning opportunities offered in clinical environments is a fundamental contributory factor in ensuring student ability to develop practical professional competence. The clinical resources of those environments are, of course, important but more important still is the enthusiasm, openness, and competence of the clinical staff. Nursing/midwifery departments must have ways of monitoring and responding to the problems practitioners face, especially with respect (a) to difficulty in differentiating between expectations for undergraduates and diploma students, (b) 'training' fatigue as a consequence of receiving too many groups of students, (c) keeping up-to-date with clinical research, and (d) the low morale some feel as a consequence of these other factors. Mentors and assessors often feel neglected by teaching staff.

To ensure the maintenance and development of quality clinical learning experiences, programme teams must liaise regularly with staff in clinical environments to foster commitment and enthusiasm and provide information. Time allocated to teachers for visits to clinical environments must be used for keeping in touch with the people with whom their students will work. Implementation structures must recognise that the quality of teaching staff visits to placements is as important as their frequency.

Principle 9.1
Degree programmes should specify clinical placement liaison structures

Degree programmes should be supported by structures for clinical placement liaison which ensure that the needs of clinical staff are given full consideration. Visits should be regular enough to make genuine dialogue possible, and should include opportunities for advice about in-service courses, research materials, and educational standards and levels.

Structures used to some effect have included the following:

- the use of joint appointments and lecturer-practitioners in clinical liaison role;
- a dedicated space for visiting HE teachers in the clinical area;

- dialogue sessions for teachers and practitioners to get to know each other's practical constraints;
- research awareness sessions provided in situ by HE teachers;
- information packages provided as the basis for discussion during visits;
- practitioners invited to address student groups.

A key frame is:

- commitment to the use of clinical liaison time for maintaining and developing clinical placement quality[3].

14.10 Quality and resources

The most important 'structures' are structures of financial resource and personnel. Unless the provision of each is at an appropriate level it is unlikely that there will be adequate time for the informed and reflective practice that nursing and midwifery education aim to promote, and on which quality client care is founded. Where care workloads are extremely high, clinical staff engagement in teaching and assessment is an additional strain. When 'delivery' of quality across a full range of teaching and research activities cannot be achieved without putting a heavy burden on all staff, the stress of providing out-of-hours support to students can constitute the final straw. Any curriculum principle is more difficult to achieve without the necessary resources

The research indicates that some of the greatest strain on staff and students is caused by resource-driven changes in placement arrangements. These changes are often sudden and can result in the closure at short notice of designated practice areas (See section 14.2. on Avoiding unacceptable compromise). However, good communication between HE providers and their clinical manager colleagues has ameliorated the worst effects, especially when this has been based on regular dialogue. This has been encouraged by recent policy for securing clinical placements supervision for undergraduates (NHS Executive 1995b), which should help to ensure regular dialogue for good practice.

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[3] In this respect, we welcome the ENB's proposed research into teachers' use of the designated 0.2 WTE contract time for clinical practice liaison (ENB 1995c).

Principle 10.1
Degree programmes should provide evidence of structures for intelligence-gathering and negotiation with major stakeholders.

A degree programme must be supported by structures for the negotiation of changes in resources which may have implications for the maintenance of the educational objectives to which education providers and purchasers commit themselves at validation.

Key structures for ensuring clinical placement resources, therefore, are:

- continuous dialogue between HE providers and individual Trusts, Consortia, and Regional Authorities for planning placements across care provider areas;
- continuous dialogue between HE providers and individual Trusts, Consortia, and Regional Authorities for co-ordinating placements across the full range of education programmes (i.e. diploma, undergraduate, post-registration, pre-registration);
- continuous dialogue between HE providers and individual Trusts, Consortia, and Regional Authorities for ensuring commitment to regular evaluation of provision.

The key facilitating frame is:

- commitment to the principle that changes in resource will not be made without time being provided for education providers to negotiate suitable alternative arrangements.

Without adequate and appropriate resources the possibility of producing a degree capable of maintaining and developing its educational and practical quality is considerably diminished, until the point of unacceptable compromise is reached. If programmes incorporate structures to ensure the educational practices of reflection and critique, students will derive some benefit from *any* context, but if they are to develop quality, research-informed clinical practice they must have the opportunity to experience a range of clinical environments which meet and wherever possible go well beyond, baseline criteria for education and practice. And if students, teachers, and practitioners are all to have sufficient time free from other commitments to be able to engage realistically in processes of educational dialogue and reflective practice, they must also have time to do so. In preparing for a degree which makes these processes happen, it is essential to ensure that there are structures for guaranteeing appropriate resources of time, personnel, space, clinical environments, and access to research/materials of many kinds.

In preparing for the degree, it is necessary to ask a series of questions in order to decide the extent of the resource that would be required to make the experience one which is educational, and at the same time prepare students appropriately for high quality practice. Among the questions to be answered are the following. To what extent have local conditions, cultures, and attitudes been audited? Does the degree have baseline criteria for making decisions about quality? Have these criteria been made explicit to all parties? Are there mechanisms for purchasers and providers to work together to examine change in clinical provision which threatens to unacceptably compromise that quality? Are there structures for promoting equitable relationships between the 'owners' of different agendas? What are the structures which minimise the vulnerability of education providers in negotiations over the provision of resources for students? The greater the number of structures for promoting educational processes that have been incorporated into the curriculum as a consequence of answering these questions, the less pressure there will be on staff, students, and others.

Principle 10.2
Degree programmes should detail the relationship between contexts of operation and the resource base

The more pressures there are on staff and students because of 'problem factors' in the context in which a degree will have to operate, the more systematically its curriculum will have to provide (a) structures, and (b) resources – in particular, resources for structuring time to enable coherence and integration and ensure the 'delivery' of a curriculum which has at its centre the educational processes in which rigorous reflective practice is grounded.

14.11 Conclusion

The research data indicates that the quality of nursing and midwifery degrees depends upon the following four things:

- the principles that will guide the processes through which attempts to realise intentions are to be enacted;
- the structures by which those principles will be enacted and promoted;
- the educational dispositions and cultural frames that will orient intentions and motivate actions;
- appropriate resource bases to support the above.

Degrees which operate with the minimum of unproductive pressure on students and staff, and are perceived by undergraduates and graduates as offering what they regard as quality preparation for joining the nursing and midwifery professions, have combined principles, structures and dispositions in a mutually supportive relationship to create degrees which have coherence. The departments which offer these degrees have worked hard to remove as much fragmentation as possible, and to institutionalise structures which are educational, participative (or democratic), and responsive to external context of education and care.

It must not be forgotten, however, that although the dynamic potential of the structural, dispositional, intellectual, and cultural frames which these departments have incorporated into their degrees is highly significant in promoting their success, the level of provision of financial resources affects the extent to which impetus from the potential can be maintained.

The principles offered here are educational principles, or principles for the construction of a curriculum for a quality undergraduate degree in nursing or midwifery. But if the quality of education affects the quality of professional practice, as most educators and professionals believe, then these are also principles for the development of quality client care. The principles are also, therefore, intended as a focus for discussion about the kind of curriculum which may contribute towards the development of quality care now and in the future.

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